Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICARE PART B SERVICES
BILLED BY COMMUNITY URGENT CARE
MEDICAL GROUP FOR THE PERIOD
JANUARY 1, 1995 THROUGH
JULY 31, 1999



Office of Inspector General

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REGION IX

AUDIT OF MEDICARE PART B SERVICES BILLED BY COMMUNITY URGENT CARE MEDICAL GROUP FOR THE PERIOD JANUARY 1, 1995 THROUGH JULY 31, 1999

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.





Region IX Office of Audit Services 50 United Nations Plaza San Francisco, CA 94102

CIN: A-09-00-00089

NOV 1 5 2001

Dr. James Loftus
Dr. Joel Geiderman
Community Urgent Care Medical Group
Cedars-Sinai Medical Center
8700 Beverly Boulevard
Los Angeles, California 90048

Dear Drs. Loftus and Geiderman:

This report provides you with the results of our joint review of the Medicare Part B payments (about \$3.7 million) to Community Urgent Care Medical Group, Inc. (Community) for services rendered from January 1,1995 through July 31, 1999. Our objective was to determine if the payments were appropriate for the services that were billed.

Community contracts with Cedars-Sinai Medical Center (Cedars-Sinai) to provide its emergency room services. As part of the agreement, Cedars-Sinai performs billing, accounting, and certain administrative functions for Community.

With the assistance of National Heritage Insurance Company's (NHIC) medical review staff, we reviewed a random, statistical sample of 100 claims containing 135 services for which Community was paid by Medicare. Our combined review disclosed that 29 of the 135 services had been overpaid. Six of these were determined to be completely unallowable, and 23 were allowed but at lesser amounts. One of the 135 services was determined to be underpaid. We identified one service that was performed but not billed; therefore, we allowed an additional payment for it.

The 29 overpaid services included:

- 23 which had been upcoded,
- 3 for which the documentation did not support that the services were performed as billed, and

• 3 for which the documentation did not support that a teaching physician was present when a resident performed the service.

Based upon our random sample, we estimate that Community received \$266,236 in Medicare overpayments during our audit period.

We concluded that the overpayments occurred because the Cedars-Sinai and Community coding staff: (1) had a lenient interpretation as to whether the documented services met the stated requirements for a particular code, and (2) in a few instances, did not follow their procedures to ensure that billings complied with Medicare's requirements.

In response to our draft report, CUCMG provided additional documentation to support its disagreement with many of our findings and conclusions (see APPENDIX C). The NHIC, in its response, concurred with our findings (see APPENDIX D). After reviewing and considering the additional documentation and conclusions, we revised some of our findings for specific services, but decided that our overall conclusions remain valid.

We recommend that Community refund the identified overpayment of \$266,236.

INTRODUCTION

BACKGROUND

Community is a professional medical corporation that contracts with Cedars-Sinai, a large nonprofit hospital located in Los Angeles, California, to operate its Emergency Medicine Department. Under the agreement, the medical center performs all cost recovery processes, including billing Medicare, Medicaid, private insurance, and other legally responsible payors and provides other administrative functions for Community.

Medicare Part A provides basic protection against the costs of inpatient hospital care. Medicare Part B covers physicians' services and a number of other items and services not covered under Part A. Each part is financed separately.

Cedars-Sinai is a major teaching hospital affiliated with the University of California at Los Angeles School of Medicine. As such, Cedars-Sinai participates in Medicare's Graduate Medical Education program, a Part A program that pays for the costs of the residents' salaries and the teaching physicians' supervision (teaching) of the residents.

Payments under Part B are administered by carriers, usually existing private insurance companies that contract with the Federal Government for this purpose. During our audit period, Transamerica Occidental Life Insurance Company¹ was the Medicare carrier for Community and Cedars-Sinai.

Medicare Part B payments to Community totaled about \$3.7 million during our audit period.

OBJECTIVE, SCOPE, AND METHODOLOGY

We conducted our audit in accordance with generally accepted government auditing standards. Our objective was to determine if Medicare's Part B payments were appropriate for the services billed.

To accomplish this objective, we reviewed a random, statistical sample of 100 claims (135 paid claim lines) from a universe of claims paid by Medicare Part B to Community with dates of service from January 1, 1995 through July 31, 1999 and with payment dates prior to September 24, 1999. This universe contained 38,680 claims for which Community was paid \$3,735,677.

We obtained copies of pertinent medical records from the patients' medical files located at Cedars-Sinai. In some instances, we obtained information from Cedars-Sinai staff and Community staff concerning who wrote specific medical record entries. In addition, we consulted with NHIC's staff about Medicare's rules.

At our request, NHIC's medical reviewer examined the medical records we obtained to determine whether they supported the services billed. The medical reviewer looked at whether the services were medically necessary, were billed using the correct descriptive codes, represented Medicare covered services, and met various Medicare reimbursement rules.

At Community, we interviewed the two physician shareholders who function as the management team for Community, three other physicians of Community who were involved in the coding of bills, and Cedars-Sinai billing staff. We also obtained documentation of various policies and procedures pertaining to the Medicare billing process at Community and Cedars-Sinai.

In addition, we used information developed by a consultant that contracted with Community to review all 54 sample services which were questioned based on an initial review by NHIC's medical reviewer. In our draft report, we identified 54 lines of service which were not correctly billed based on the medical records and

¹ Effective December 1, 2000, NHIC assumed the carrier responsibilities from Transamerica Occidental Life Insurance Company.

related information provided to us. The 54 lines of service were reduced to 29 based on additional information provided by the consultant. In certain instances, the additional information eliminated an error and in other instances it reduced the dollar value of an error. The final report describes the 29 errors, 23 related to upcoding and six related to documentation.

During our review of medical records, we identified one service for which Community did not bill Medicare. Although the service that was not billed had not been subjected to the claims adjudication process, we used the claim to reduce the dollar value of the error, which worked to lower the dollar amount identified as an overpayment.

We did not review Community's or Cedar-Sinai's internal controls over the processing of Part B Medicare claims because a review of such controls was not necessary to accomplish the objectives of this audit.

Our fieldwork was performed from May 2000 to July 2001 at Community and Cedars-Sinai.

FINDINGS AND RECOMMENDATION

Our audit, using statistical sampling techniques, disclosed that Community was overpaid for 29 of the 135 sampled services included in the sample of 100 claims. We reviewed the medical records for all services in the sample to determine if services were: (1) medically necessary, (2) billed using the correct descriptive codes, (3) covered services, and (4) compliant with Medicare reimbursement rules. We did not find any services in the sample that were determined to be medically unnecessary or were not covered by Medicare. However, we did find 23 services which were billed using incorrect descriptive codes and 6 services which did not comply with Medicare rules regarding documentation of services.

Six of the services were determined to be completely unallowable, and 23 were allowed but at lower reimbursement amounts than those originally paid. In addition, one service was underpaid and one service that was performed but not billed was identified and allowed. We estimate that Community was overpaid \$266,236 (mid-point estimate). Details summarizing our sample methodology and statistical projection are contained in Appendices A and B, respectively.

The 29 overpayment errors fell into the following 3 categories:

• Upcoded services (23),

- Documentation did not support that the services were performed as billed (3),
- Documentation did not support that a teaching physician was present when a resident performed the service (3).

We concluded that Cedars-Sinai and Community coding staff had a lenient interpretation as to whether the documented services met the stated requirements for a particular code, and in a few instances, did not follow their procedures to ensure that billings complied with Medicare's requirements.

UPCODED SERVICES

Our review found that 23 of the 135 examined services were billed using numeric coding descriptors (i.e., procedure codes) that described services more complex than those actually provided (a condition commonly referred to as upcoding). One of the 135 examined services was determined to have been billed one CPT code lower than it could have been, and thus, was underpaid (for a more complete description of this underpaid service, see "UNDERCODED SERVICE" on page 8 of this report).

Medicare pays for emergency department visits (one of the categories of physician evaluation and management services) based upon the coding descriptions developed by the American Medical Association (AMA) and published in its <u>Current Procedural Terminology</u> reference book. There are five levels for emergency department visits. The various levels encompass the wide variations in skill, effort, time, responsibility, and medical knowledge required for the prevention or diagnosis and treatment of an illness or injury.

There are three key components in selecting the appropriate level, i.e., determining the nature and complexity of the: (1) history, (2) examination of the patient, and (3) medical decision making. There are other contributory factors (counseling, coordination of care, nature of the presenting problem, and time) that may impact the selection of the proper level of care to bill to Medicare.

Of these 23 upcoded services, 18 were upcoded 1 level and 5 were upcoded 2 levels.

² The <u>Current Procedural Terminology</u> is published by the American Medical Association. It is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties.

SERVICES NOT PERFORMED AS BILLED

In three instances, the documentation in the medical record did not support the services that were billed. Of the 3 services, 2 were for an interpretation and report of a

12-lead electrocardiogram (EKG), and 1 was an external cardioversion service.

For one of the EKGs, the medical record did not contain the tracing or the physician's interpretation of the tracing. For the other EKG, the medical record did not contain an interpretation of the EKG. In these cases, the payments were determined to be unallowable.

For the external cardioversion service, the medical record indicated that the patient had an <u>internal</u> defibrillator. As a result, the service that was billed was not possible to render.

In addition to the three services described above, one of the claims that was billed did not include an EKG that was actually performed and documented. NHIC's medical reviewer allowed this additional service and we used it to reduce the dollar value of error in the sample.

LACK OF DOCUMENTED TEACHING PHYSICIAN PRESENCE

In three instances, Community billed for services performed by residents without documentation that teaching physicians were present. Services performed by a resident without a teaching physician's presence are not reimbursed by Medicare Part B because the residents' salary and the costs for the teaching activities that the faculty provide to the residents are paid to the hospital under Medicare Part A. Payment for services provided by a resident under Part B would represent double payment.

Teaching physicians who supervise residents may be reimbursed by Medicare Part B for their own professional services to patients even if a portion of the services was actually provided by the resident. In this case, however, the teaching physician must be present when the service was performed by the resident and must document that presence in the medical record.

Federal law, implementing regulations, and Medicare issued guidance has long required that teaching physicians billing Part B provide the services themselves or be physically present while a resident provides the service. Federal regulations applicable to services in our sample before July 1, 1996 (42 Code of Federal

Regulations (CFR) 405.521 (b)), stated that payment is appropriate under Part B when:

"...the attending physician furnishes personal and identifiable direction to interns or residents who are participating in the care of the patient."

Medicare instructions relating to the providing of services of supervising physicians in a teaching setting (Intermediary Letter No. 372 and its subsequent guidance) provided that:

"If Part B bills are submitted for services performed by a physician in either the emergency room or in any part of the outpatient department, the hospital records should clearly indicate either that the supervising physician personally performed the services; or he functioned as the patient's attending physician and was present at the furnishing of the services for which payment is claimed." (Emphasis added)

Federal regulations applicable to services after June 30, 1996 (42 CFR 415.172 (a)), provided that:

"General rule. If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought."

Furthermore, 42 CFR 415.172 (a) (2) states that:

"In the case of evaluation and management services, the teaching physician must be present during the portion of the service that determines the level of service billed."

In addition, 42 CFR 415.172 (b) addresses certain documentation requirements:

"...the medical records must document the teaching physician was present at the time the service is furnished....In the case of evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical records." (Emphasis added)

One of the three services that lacked documentation of a teaching physician's presence was rendered before July 1, 1996 and two were rendered after that date.

In all three instances, handwritten notes by a resident documented the development of the patient's pertinent medical history, examination of the patient, and the medical decision that was made. The residents signed these notes. However, the attending physician simply added his signature without any additional notes; thus, there was no documentation of the teaching physician's presence at the time that the resident examined the patient.

There were 26 emergency department visits in our sample that involved residents. Except for the three discussed above, we found that the teaching physicians had adequately documented in the medical records the services they had personally performed.

Community's physicians explained that Cedars-Sinai's policy is that attending physicians are to see all patients, that the medical care is to be rendered by the attending physicians, and that the residents are there for the purpose of learning. The physicians also explained that their signature on the treatment record meant that they had seen the patient. However, this does not meet Medicare's documentation requirements.

UNDERCODED SERVICE

One service was billed at a service level of lower complexity than the medical record actually supported. In this instance, Community billed an emergency department visit using the CPT code 99282. The medical reviewer allowed the CPT code 99283, a higher reimbursed service, based upon the documentation in the medical record. We included the underbilling in the sample analysis, effectively reducing the amount of the identified overpayment.

RECOMMENDATION

We recommend that Community refund the identified overpayment of \$266,236.

SUMMARY OF FINAL FINDINGS

In our draft report, we identified 54 services that had been overpaid. Community engaged a third-party coding consultant to review the 54 services and gather additional documentation to support the claims. NHIC's medical reviewer considered the additional information and documentation that Community and its consultant provided to support its position on the findings presented in the draft report. As a result of his review of this additional material, the medical reviewer revised many of his decisions supporting our findings in the draft report. In certain instances the additional information eliminated an error and in other instances it

reduced the dollar value of the error. However, the OIG and NHIC concluded we did not agree with Community's position on 29 sample services.

COMMUNITY'S COMMENTS

Community pointed out that the majority of the upcoding errors for evaluation and management services (E&M) occurred prior to October 1995 when the Documentation Guidelines for Evaluation and Management Services was first published by the AMA and HCFA. Community's consultant performed an analysis of the 54 errors as shown in our draft report and determined that Community's error rate was less than that disclosed for Medicare services in a recent OIG report on the Department's financial statements. Community concluded that it had appropriately applied the E&M Guidelines because its error rate was less than that shown in the OIG report. And, in those instances where the documentation guidelines were ambiguous, Community felt that it had adopted a reasonable interpretation.

Community maintained that the medical record for sample number six complied with the rules and regulations for Medicare teaching physician reimbursement that existed at the time the service was provided, and that the medical record provided clear evidence that the teaching physician was present when the emergency room service was rendered.

With respect to the cardioversion service (a service not performed as billed), Community agreed that the service was inappropriately billed. However, it thought that the circumstances involved in this error, as well as the low number of times this service was claimed, made the error sufficiently unique to preclude any extrapolation to the universe.

NHIC'S COMMENTS

In a response to our draft report (see Appendix D), NHIC indicated that they reviewed and concurred with our findings.

OIG'S COMMENTS

Contrary to Community's statement that the <u>Documentation Guidelines for Evaluation and Management Services</u> was released in October 1995, it was published by HCFA and the AMA in November 1994. In December 1994, Transamerica published a newsletter (number 80) that made these documentation guidelines effective beginning in January 1995. As such, the guidelines were effective for the entire period of our audit. Therefore, we did not exclude any of our findings from Community's revised error rate of 21 percent. Community's comparison of its error rate with the error rates of any other provider or set of

providers does not relate to the Medicare regulations which determine allowable charges to the Medicare program. Our review of the 100 sample claims identified 23 claim lines or services which were upcoded and 6 which were not supported by appropriate medical records.

Regarding sample service number six, involving a teaching physician service that Community thought had been properly documented, NHIC's medical reviewer wrote that he found no evidence that the emergency room physician was present during the resident's work-up, or that the attending physician participated in the patient's care. The medical reviewer also noted that the guidelines that he followed in determining whether the service was allowable were in effect beginning in 1977. Thus, he concluded that Community's physician had not followed the rules and regulations in effect at the time for teaching physician services.

Concerning the extrapolation of the cardioversion service to the universe, the projection of the error in the random sample was limited to the universe from which the sample was drawn and is the only statistically valid application.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services' reports are made available to the public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See

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45 CFR Part 5.) As such, within 10 business days after the final report is issued, it will be posted on the world wide web at http://www.hhs.gov/progorg/oig.

To facilitate identification, please refer to Common Identification Number A-09-00-00089 in all correspondence relating to this report.

Sincerely,

Lori A. Ahlstrand

Regional Inspector General for Audit Services

Enclosure



Sampling Methodology

Objective:

Our audit objective was to examine a statistical sample of Medicare payments made to Community to determine if the payments were appropriate for the services that were billed.

Population:

The population was all Medicare Part B claims for which the carrier had paid Community for services with dates of service from January 1, 1995 through July 31, 1999 (and with payment dates prior to September 24, 1999) that were billed indicating that one of the co-heads of the emergency department had actually performed the services. For this population, Community was paid \$3,735,677 on 38,680 claims.

Sampling Unit:

The sampling unit was one Medicare Part B claim paid to Community.

Sampling Design:

A single stage, unrestricted random sample was used.

Sample size:

Our sample size consisted of 100 claims. For the 100 claims, there was a total of 135 paid claim lines.

Estimation Methodology:

Using the Variables Appraisal Program of the Office of Audit Services (RATS-STATS), we calculated the 90 percent two-sided confidence interval using the difference estimator.

\$411,095

Variables Projection

The lower and upper limits of the dollar value of overpayments are shown at the 90 percent confidence level. We used our random sample of 100 claims out of the universe of 38,680 claims (51 ,143 paid services) to project the value of the overpayment. The result of this projection is presented below:

Difference Value Identified in the Sample	\$ 1,063
Point Estimate of Overpayment	\$411,095
Lower Limit	\$266,236
Upper Limit	\$555,954
Point Estimate by Type of Error	
Point Estimate - Upcoded Services	\$288,004
Point Estimate - Lack of Documented Teaching Physician Presence	\$ 71,423
Point Estimate - Services Not Performed as Billed	\$ 55,811
Point Estimate - Benefit for Service Not Previously Billed	\$ (4,143)

Total of Point Estimate by Type of Error



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James J. Loftus, M.D. Joel M. Geiderman, M.D.

June 1, 2001

Ms. Lori A. Ahlstrand Regional Inspector General for Audit Services Department of Health and Human Services, Region IX Office of Inspector General 50 United Nations Plaza San Francisco, California 94102

Re: **CIN**: A-09-00-00089

Draft Audit Report: Audit of Medicare Part B Services Billed by Community Urgent Care Medical Group for the Period January 1, 1995 through July 1,1999

Dear Ms. Ahlstrand:

This letter is submitted in response to the draft audit report dated March 2, 2001 (the "Report") issued by the Office of Audit Services ("OAS") with respect to emergency department services provided by Community Urgent Care Medical Group (the 'Group') for the period January 1, 1995 through July 3 1, 1999 and billed to Medicare Part B, as modified to reflect revised findings of OAS' medical reviewer following a meeting on April 25, 2001.

The Report Affirms that All Services Were Medically Necessary and Appropriately Rendered.

As a preliminary matter, we wish to stress that the OAS medical reviewer was requested to review, among other things, whether the services in question were medically necessary and represented Medicare covered services. There is no suggestion in the Report that any of the 135 services that formed the basis of the audit were unnecessary, substandard, or otherwise raised any quality of care issues. Rather, the audit confirms the Group's commitment to providing high quality care to all individuals who present to the emergency department -- a department that provides substantial uncompensated care, sees over 70,000 patients each year, and maintains a Level I Trauma Center. We have also been informed that the audit was not precipitated by any allegation of fraud or wrongdoing by any party.

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II. The Report Found that One Hundred Percent? Services were correctly

All services billed using critical care codes were found by the OAS medical reviewer to have been correctly billed. There was not a single instance of upcoding of an evaluation and management (E&M) service to a critical care service.

III. Evaluation and Management Services.

The great majority of the overpayments alleged in the Report derive **from** evaluation and management (E&M) services. The controversy surrounding the E&M guidelines and the difficulty in applying the rules relating to E&M services is well known. Currently, providers may utilize either of two different sets of E&M guidelines (the 1995 and the 1997 guidelines) that coexist. There are also draft revisions proposed by HCFA in a June 2000 town meeting that represent a substantial re-thinking of the E&M coding system, A recent study of E&M coding of emergency department medical records found significant disparities among experienced coders. Bentley, **et** al., Reliability of Assigning Correct **E&M** Codes: Is Compliance Possible?, **Academic Emergency Medicine 8:479** (2001).

It is also important to understand the methodology used by OAS in conducting its audit. The **findings** in the Report are the coding interpretation of a single medical reviewer. The findings by that reviewer were not validated by a second, blind review. They were not compared to norms in similarly-situated tertiary hospital emergency departments. They are the judgments of a single individual, with each judgment extrapolated across an enormous **universe** of claims.

Our review of the charts indicated that the vast majority were appropriately coded. In order to test our review, we engaged an independent third party coding expert, Cathy Plunkett at 3M Health Information **Systems Consulting** Services, whose report is attached to this letter as Appendix A. As described more fully in that report, her review team is made up of Certified Professional Coders, each with over 20 years experience in health care. Ms. Plunkett and her team provided train-the-trainer programs on E&M coding for HCFA and the Medical Association of Georgia in 1992 when the levels were first designed, and continues to provide these programs nationwide as changes in documentation requirements occur. She and her team have also served as the independent auditor for OIG-directed PATH II Program coding and billing reviews.

Of the 27 E&M services identified by the OAS reviewer as incorrectly **upcoded**, the independent expert concluded that:

- 18 were accurately billed or billed at a *lower* level than actually rendered
- 7 were coded only a single level higher than reflected by the documentation.

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Only 2 services represented an **upcode** of more than 1 level, and these may be the result of lost documentation (dictation reports) subsequent to coding.

For the four and one half year period under audit, 69% of the overpayment identified by the independent expert related to E&M services rendered between January and October 1995, prior to or concurrent with the official adoption of the 1995 guidelines. The 1995 error rates are not representative of the error rates in later years.

Excluding the E&M visits prior to October 1995, when the E&M Guidelines were first released, the independent expert found an overall error rate of under 4% and an E&M error rate of under 2%. By way of comparison, a recent OIG study found that the overall Medicare fee-for-service overpayment rate for FY 2000 was 6.8%, while that for FY 1996 was double that number. Department of Health and Human Services Office of Inspector General, *Improper Fiscal Year 2000 Medicare Fee-For-Service Payment* (A-17-00-02000). The same study found average error rates for E&M services to be particularly high, with the percent of services in error for 99214, for example, exceeding 37% for FY 2000. We therefore believe the Group appropriately applied the E&M Guidelines and, where those Guidelines are vague or ambiguous, adopted a reasoned and moderate standard of interpretation.

IV. Teaching Physician Services.

The Report indicates that of 26 emergency department services that involved residents, 23 were found by the **OAS** reviewer to have complied with all Medicare teaching physician rules and regulations. Of the remaining three services, one was furnished prior to the effective date of the new teaching physician regulations on July 1, 1996, and there is nothing in Intermediary Letter No. 372 as quoted in the Report that indicates the need for a separate note signed by the attending physician We concur with the findings for the other two services, but we **would** note: (1) that while the record may not satisfy all technical Medicare documentation guidelines, there is clear evidence in both cases that the attending physician was present and involved in the patient's care; and (2) in one case, the record reveals that the attending physician even entered the diagnosis in his own handwriting.

V <u>Miscellaneous Services</u>.

The final area identified in the Report relates to three services that **the** Audit indicates were not performed as billed. Two relate to EKG interpretations, and one to a cardioversion. We concur that the documentation available in the charts do not include the EKG interpretations, although **in** one of the cases it is clear **from** the context of the chart that the interpretation was performed as a repeat EKG was ordered by the treating physician, and there was a clear dictation transcription error as the dictation indicates that the "EKG showed congestive heart failure." With respect to the cardioversion, the circumstance of this service is **sufficiently** unique that the propriety of seeking to extrapolate it across a constellation of claims is highly questionable. Here, there was a charge for an external defibrillation where an internal defibrillator was reprogrammed in the emergency room and the patient was

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cardioverted from ventricular tachycar lia to normal sinus rhythm. We do not believe there is a basis for extrapolating this event, when the in our 'experience is unique. The code for external cardioversion appears in the entire universe of 38,660 claims a total of 50 times. It is difficult to imagine the event under audit occur ing again in that universe.

V I . Conclusion.

In conclusion, the records reflect that a uniformly high level of care was provided. Additionally, our review and the review of an independent coding expert indicates that the vast majority of the **services** questioned in the Report were correctly billed, and we intend **to** vigorously defend those claim,

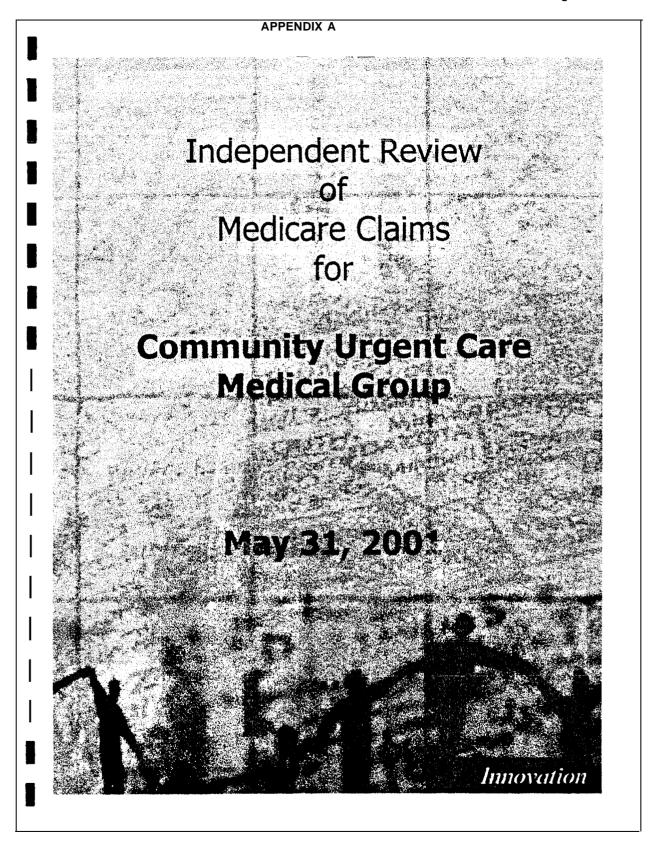
We appreciate the opportunity to respond to the draft report.

d .

Joel Geiderman, M.D.

Enclosure as noted.

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Consulting services
3M Health Information Systems

100 Ashford Center North suite 200 Atlanta, GA 30338-4844 770 394 8800

3M

May 31, 2001

Eric B. Gordon, Esq. McDermott, Will & Emery 2049 Century Park East Los Angeles, CA 90067-3208

Dear Mr. Gordon:

3M Health Information Systems Consulting Services, ("3M Consulting"), a business unit of the Minnesota Mining and Manufacturing Company ("3M"), is pleased to provide this report of our independent review of the 100 claims submitted by Community Urgent Care Medical Group in response to a review by the Office of Inspector General Office of Audit Services ("OAS"). The purpose of this review was to assess the records to determine whether the medical record and related documentation supports the code billed or the code assigned by OAS, or whether the medical record and related supporting documentation supports a different code.

BACKGROUND AND CREDENTIALS OF 3M HIS CONSULTING SERVICES

3M Consulting provides a wide range of services to the healthcare industry nationwide. We conducted the coding, documentation and billing review for **the** first OIG-directed PATH II Program audit at a major university teaching hospital and continue to represent providers nationwide on similar regulatory matters. We provided train-the-trainer programs on evaluation and management service level coding for HCFA and the Medical Association of Georgia in 1992 when the levels were **first** designed, and we continue to provide these programs nationwide as changes in documentation requirements occur. Most recently we have participated in speaking **engagements** sponsored by **Part B News and American Health Lawyers Association** on evaluation and management services, specifically changes in documentation requirements for critical care with Dr. Paul Rudolph (medical officer at HCFA). Our review team is made up of Certified Professional Coders, all with **over** 20 years of experience in healthcare.

Healthcare consulting comprises 100 percent of our business. Our team of industry experts includes seasoned physicians, certified public accountants, registered nurses, industrial engineers, medical record/HIM specialists, billing and coding specialists, reimbursement specialists, and operations and management experts. We frequently serve as outside experts to Arthur Andersen and to numerous national, regional and local law firms related to coding, documentation, and billing issues.

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Mr. Eric Gordon, Esq.
McDermott, Will & Emery
Re: Community Urgent Care Medical Group
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3M Consulting offers services in various areas, including coding, documentation and billing reviews, compliance plan development, PATH II (Physicians at Teaching Hospitals) audits, coding and documentation training for physicians and employees, physician practice compliance services, Medicare and Medicaid reimbursement, CPT/ HCPCS reviews and clinical resource management.

PROJECT SCOPE AND APPROACH

3M Consulting performed a review of 54 claims for services that included:

- 27 services that had been **upcoded** based on the OAS report;
- . 1 service that had been downcoded based on the OAS report;
- 3 services that were identified in the OAS report as not meeting the teaching physician presence guidelines;
- 2 services that were identified in the OAS report as **EKG** interpretations where the documentation did not support an interpretation by the emergency physician;
- 1 service identified in the OAS report involving a charge for external cardioversion that was not perform&, and,
- 20 services that were identified in the OAS report as being correctly coded.

We reviewed the medical records and submitted charges for the following:

- Reviewed the documentation for compliance with the July 1, 1996 requirements for Physicians at Teaching Hospitals;
- Confiied the accuracy of the E&M levels, as supported by the documentation and the
 accuracy of the procedural CPT code assignments;
- Identified the correct billing codes and report our specific findings relative to potential overbilling or underbilling;
- Maintained a database of each record reviewed, including physician, and specific reasons for exception; and,
- Compared our findings with those of the OAS reviewer.

FINDINGS

We reviewed 54 services totaling \$16,351.60 in submitted charges, representing \$5,366.15 in estimated Medicare allowed payments. Based on our review, the estimated Medicare allowed payments should have been \$4,817.79. We found \$617.35 in overpayments and \$68.99 in underpayments, with a net overpayment of 5548.36. Our findings in comparison to the results of the OAS review are as follows:

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Evaluation and Management Services

- For 19 services, we agreed with the OAS reviewer that the services were coded accurately based on the documentation.
- 2 services billed as 99282 were determined to be upcoded by the OAS reviewer by one level ofservice (R1.2.1): * and * We disagreed with the reviewer's assessment of both of these cases. The documentation supports at a minimum: an expanded problem-focused history, expanded problem-focused exam and low-complexity medical decision-making.
- 7 services billed as 99283 were determined to be upcoded by the OAS reviewer by one level (R1.3.2):

 *
 and
 *
 We disagreed with the reviewer's assessment of level 2 on two of these cases. Our review found that the documentation supported 99283 for *
 and
 *
 We agreed with the reviewer's assessment on the remaining five cases.
- 3 services billed as 99284 were determined by the OAS reviewer to be upcoded by two levels (R1.4.2): and We disagreed with the reviewer's assessment of two and' * and found that the documentation supported 99284 as of these cases billed. Patient * is a unique case in that it appears that portions of the medical record are missing. This psychiatrically disturbed patient gave one name when she presented to the Emergency Department and another name when she arrived on the psychiatric unit. The patient's name changed from * to * In all likelihood, the patient's medical condition contributed to the loss of part of her chart. The OAS reviewer assigned a level 2 without use of specific criteria for assessing the documentation but rather elements of the patient's condition. Using the documentation that was available from the nursing notes, the psychiatric unit notes and the discharge summary, it was apparent that a complete psychiatric evaluation was performed in the Emergency Department, the patient was placed in restraints and given IV Haldol for sedation in an attempt to minimize the risks of the patient's causing harm to herself or others. The history would have been waived due to the patient's altered mental status. It is our opinion that this service was high complexity and supported at least a level 4 as billed.
- 10 services billed as 99284 were determined by the OAS reviewer to be upcoded by one level (R1.4.3):
 - * and * We agreed with the reviewer's assessment of one of these cases,
 * In one case, * we found that the documentation supported a level 5
 service. On the remaming eight cases, we found that the documentation was sufficient to support a level 4 as billed.
- 1 service billed as 99285 was determined by the OAS reviewer to be upcoded by three levels (R1.5.2):
 * We disagreed with the reviewer on this case and found that the documentation supported 99283.
- 1 service billed as 99285 was determined by the OAS reviewer to be upcoded by two levels (R1.5.3):
 * We agreed with the reviewer's findings on this case.

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- 2 services billed as 99285 were determined by the OAS reviewer to be upcoded by 1 level (R1.5.4):
 * and * We disagreed with the reviewer's determination on each of these cases and found that the documentation supported 99285 as billed.
- 1 service billed as 99285 was determined by the OAS reviewer to be upcoded by 1 level (R1.5.4): * We agreed with the reviewer's determination that this service was documented as 99284.
- 1 service billed as 99282 was determined by the reviewer to be undercoded by one level of service (R2.2.3): * We agreed with the reviewer that this service was under coded, but disagreed that the appropriate level was 99283. We believe the level should have been 99284.

Of the 27 **E/M** services downcoded by the reviewer, we found that in 18 of the services, the documentation was present to support or exceed the level of service billed under the 1995 **AMA/HCFA** guidelines for history, examination and medical decision-making. In seven of the remaining nine cases, the level of service exceeded that documented by a single level only. There were only two cases that our review determined to be **upcoded** more than one level based on the documentation:

* and * In both of these cases, there was a question as to whether the entire medical record was available for review. The record that was dictated by the emergency physician was not located for review in either case.

Teaching Services

• Three services were determined by the reviewer not to meet the July 1, 1996 physicians at teaching hospitals guidelines for documentation of presence and involvement in the key elements (R13):* and * Although we found that in each case there was sufficient evidence to support physician presence and involvement in the patient's care, the documentation on * and * did not satisfy the July 1, 1996 guidelines for documentation of involvement in each of the three elements. Patient * service occurred prior to the 1996 guidelines, and we believe the documentation of the physician's signature and entries into the clinical management system did support the presence rules in effect at that time. Prior to July 1, 1996, there were no guidelines requiring documentation to support each of the key elements, only documentation to support presence and participation in the patient's care. This was clearly documented by the attending physician's participation in determination of the diagnosis and preparation of the discharge instructions for the patient.

Other Services

- Two services related to EKG interpretations that the reviewer did not find documented (R6):
 * and * On patients * and * we agreed with the reviewer that specific documentation to support the EKG interpretation was not found.
- One service was inadvertently coded as an external defibrillation, Patient * (R6). Gut of
 the entire universe of over 38,000 claims, CPT 92960 was used approximately 50 times. We

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agreed with the reviewer that this service was not performed; however, we believe this to be a posting error.

 One critical care service reviewed by the OAS reviewer was coded accurately based on the documentation. We agreed with this determination.

DISCUSSION OF E/M SERVICES:

The audit template provided by the OAS, "Medical Reviewer's Decision on Difference in Level of Key Components Between Code Billed and Code Allowed," suggests that where the reviewer downcoded the level of service, the history and exam components were insufficient in the majority of cases when a lower level of service was determined. We did not **find** that the documentation of history and exam were insufficient in most of these cases. We believe these differences in opinion may relate to the following:

- The reviewer did not identify all elements of the HPI: location, context, quality, timing, duration, severity, modifying factors, and associated signs and symptoms that were documented in the patient history.
- The reviewer may not have considered the review of systems documented as part of the HPI in the physician's history.
- The reviewer may have relied exclusively on the 1997 delayed guidelines for physical examination that require a much more stringent documentation than the 1995 AMA/HCFA guidelines that are still available to be used by the provider.

To make a lower determination on several of the cases, the reviewer used medical **decision-making** complexity. Complexity of medical decision making is subjective under the 1995 **AMA/HCFA** guidelines and is **determined** based on the nature of the presenting problem, number of diagnoses or management options, amount and complexity of data to be reviewed, and risk of complication and/or morbidity or mortality. Most carrier reviewers have been trained to use the point assignment system that is used to rate each component:

- Number of diagnoses or treatment options: 3 points for new problem to examiner; no
 additional workup planned or 4 points for new problem to examiner; additional workup
 planned. By nature of the presenting problems in the emergency department setting, almost
 every patient seen is new to the examiner and would start out as a level 3 or 4, based on
 whether any additional workup is planned.
- Amount and/or complexity of data to be reviewed: Points for clinical lab tests, radiology test, medicine section tests (including EKG), discussion of case with another healthcare provider. The majority of level 4 and level 5 patients in this sample had laboratory tests, radiology tests, EKG and documentation of discussion with another healthcare provider (primary physician). This would represent extensive data and support high complexity medical decision-making.
- The final element is related to the Medicare Table of Risk. Low risk is defined as a patient
 with two or more self-limited minor problems, stable chronic illness, or acute uncomplicated

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illness or injury receiving treatment options such as over-the-counter drugs or **IV** fluids. Moderate risk is defined as a patient with one or more chronic illnesses with mild exacerbation, two or more stable chronic illnesses, undiagnosed new problem with **uncertain** prognosis, acute illness with systemic symptoms, or acute complicated injury and may receive treatments such as **IV** fluids with additives or prescription medications. High risk is **defined** as a patient with one or more chronic illnesses with severe exacerbation, acute. of chronic illnesses or injuries that may pose a threat to life or bodily functions, or an abrupt change in neurological status (Conditions all consistent with need for admission to the hospital).

EXTRAPOLATION

We applied the methodology used by the Department of Health and Human Services, Office of Inspector General ("HHS") to extrapolate an estimated potential overpayment amount. We used the population of claims provided by HHS, the variables appraisal report, and the Variables Appraisal Program of the Office of Audit Service (RATS-STATS) to calculate these results. The revised point estimate (overpayment amount) based on our record review findings is approximately \$150,918 compared to the OAS figure of approximately \$469,000.

EXTRAPOLATION ISSUES

The 1995 **AMA/HCFA** documentation guidelines for **E/M** services were not officially adopted by HCFA until fall of 1995. When these guidelines were released, HCFA had indicated that reviews of documentation would not occur until 1996. Five of the services downcoded by the reviewer occurred between January and October of 1995:

* and * These five services represented an overpayment of \$245.22 or 69% of the total E&M overpayment (\$353.10), determined from our review to be due to the E/M documentation not supporting the level of service billed. It is clear from the review that the coding improved significantly in relation to the 1995 AMA/HCFA documentation guidelines for evaluation and management services for subsequent years. Due to the fact that the guidelines were new in 1995 and providers and coding personnel were in the process of learning the guidelines, these services should not be considered in the extrapolation. If the 1995 E/M items were removed from the population, the E/M error rate on the remaining years would be less than 2% and the overall error rate for the sample would be under 4%.

Case number 16, patient * is an anomaly. Out of over 38,000 claims in the total sample universe, CPT 92960 was used approximately 50 times. In this case, an external cardioversion was inadvertently charged on a patient having an internal defibrillation device. The record states that a cardiologist reprogrammed the AICD to deliver a shock, and the patient was successfully cardioverted. We recommend that this record be removed from the sample and treated as a simple overpayment in the amount of \$157.65.

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Mr. Eric Gordon, Esq. McDermott, Will & Emery Re: Community Urgent Care Medical Croup May 31, 2001 Page 7 of **7** We appreciate the opportunity to assist with this review. Attached are the following: • Description of Findings Codes Findings in Sample Findings By Code By Patient Detail Findings by Patient Sincerely, Minnesota Mining and Manufacturing Company By: Cathy Plunkett Director 3M HIS Consulting Services Enclosures S:\Data\Maryann\Shared\Engagements\MWE-CH\vMWECH 053101.doc

Community Urgent Care Medical Group Description of Findings Code

RO Accurately coded Service(s) Upcoded R1 R1.2.1 Service billed as 99282, audited 99281 R1.3.1 Service billed as 99283, audited 99281 R1.3.2 Service billed as 99283, audited 99282 R1.4.1 Service billed as 99284, audited 99281 R1.4.2 Service billed as 99284, audited 99282 R1.4.3 Service billed 99284, audited 99283 R1.5.2 Service billed as 99285, audited 99282 R1.5.3 Service billed as 99285, audited 99283 R1.5.4 Service billed as 99285, audited 99284 R2.2.4 Service billed as 99282, audited 99284 R2.4.5 Service billed as 99284, audited 99285 R6 Service was not documented R13 Documentation did not support 1996 PATH guidelines **R15** Documentation supported pre-1996 Teaching guidelines R18 Critical care time not supported in documentation R25 Documentation was not available for review R90 Service billed at level other than stated by reviewer.

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Community Urgent Care Medical Group Findings in Sample

Reviewer CD	CPT CD REV	Units	Charge Am!	Allowed	Audited	Net D	if. Under	Ove
RO	RO	20	\$6,993.00	\$2,297.78	\$2,297.78	\$0.00	so.00	\$0.0
R1,2.1	RO	2	\$216.00	\$73.45	\$73.45	\$0.00	\$0.00	\$0.00
RI .3.2	RO	2	\$372.00	\$131.69	\$131.69	SO.00	\$0.00	\$0.00
Rt. 3. 2	R1. 3. 2	5	\$930.00	\$329.02	\$162.62	(\$146.40)	\$0.00	5146. 40
R1. 4. 2	RO	2	\$627.00	\$201.30	\$201.30	\$0.00	\$0.00	So. 00
RI. 4. 2	R25	1	\$276.00	\$94.36	\$94.36	\$0.00	\$0.00	\$0.00
R1. 4. 3	RO	8	\$2,433.00	5792. 45	5792. 45	so. 00	\$0.00	\$0.0
Rl . 4. 3	R1.4.3	1	\$304.00	\$99.06	\$64.96	(\$34.10)	\$0.00	\$34.1
Rl . 4. 3	R2. 4. 5	1	\$323.00	\$102.07	\$106.32	\$4.25	54. 25	50. 00
R1. 5. 2	R1.5.3	1	\$501 . oo	\$160. 32	\$66. 51	(\$93.61)	80.00	\$93.8
R1. 5. 3	R1. 5. 3	I	5366.00	\$155.90	SW 96	(\$90.94)	\$0.00	\$90.9
Rl . 5. 4	RO	2	\$1,002.00	\$321.66	\$321.86	\$0.00	\$0.00	\$0.00
Rl . 5. 4	R1. 5. 4	1	\$388.00	\$155.90	\$99. 06	(\$56.84)	\$0.00	\$56.84
R13	R13	2	\$509.00	\$168.78	\$0.00	(\$166. 76)	\$0.00	\$168.78
R13	R15	1	\$186:00	ә о 1.62	561.62	\$0.00	\$0.00	\$0:00
R2. 2. 3	R22. 4	1	\$109:00	\$37.19	\$101.93	564.74	S64. 74	\$0:00
R6	ALT CPT	1	\$636.00	\$157.65	5156. 92	(\$0.73)	\$0.00	\$0:73
R6	R6	2	\$166.60	\$25.75	\$0.00	(525. 75)	so. 00	\$25.75
	_	54	\$16,351:60	\$5,366.15	\$4,817.79	(\$548.36)	\$68.99	\$617.3

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Finding	s By Code By	, Patier	ıt					
OAS 3M	Patient	Units	Chg. Am	t Allowed	AuditedL	ifference	Under	Over
RO RO	*	1	\$186.00	\$65. 16	\$65. 18	\$0.00	\$0.00	\$0.00
	*	1	\$501.00	5160. 93	\$160. 93	\$0.00	\$0.00	\$0.00
	*	1	\$472.00	\$156.92	\$156.92	\$0.00	S0. 00	\$0.00
	*	1	5695. 00	\$206.44	\$206.44	\$0.00	\$0.00	\$0.00
	*	1	\$472.00	\$156.92	\$156.92	50.00	50.00	\$0.00
	*	1	\$501.00	\$160.93	\$160.93	\$0.00	\$0.00	\$0.00
	*	1	\$323.00	\$101.93	\$101.93	so. 00	\$0.00	\$0.00
	*	1	\$323.00	6101.93	\$101.93	\$0.00	\$0.00	\$0.00
	*	1	\$276.00	\$94.36	\$94. 36	\$0.00	\$0.00	so. 00
	*	1	\$276.00	\$94.36	\$94.36	\$0.00	\$0.00	\$0.00
	*	1	\$472.00	\$166. 92	\$166.92	\$0.00	\$0.00	50.00
	*	1	\$186.00	\$66.65	\$66.65	\$0.00	\$0.00	\$0.00
	*	1	\$109.00	533. 42	533. 42	\$0.00	\$0.00	\$0.00
	*	1	\$472.00	\$156.92	\$156.92	\$0.00	50.00	\$0.00
	*	1	\$276.00	894. 36	\$94.36	\$0.00	\$0.00	\$0.00
	*	1	\$304.00	\$99. 37	\$99. 37	\$0.00	so. 00	\$0.00
	*	1	\$501.00	\$160.32	\$160.32	\$0.00	\$0.00	\$0.00
	*	1	\$186.00	\$66. 51	\$66. 51	\$0.00	so. 00	80.00
	*	1	\$276.00	\$94.36	\$94.36	\$0.00	\$0.00	\$0.00
	*	1	\$186.00	\$66. 65	\$66.85	\$0.00	so. 00	50. 00
	Subtotals:	20	\$6,993.00	S2. 2S7. 78	\$2,297.78	\$9. 99	\$0.00	§9. 99
R1. 2. 1 RO	*	1	\$109.00	\$37. 19	\$37. 19	ΨV.UU	\$0.00	ŲU,UU
		1	\$109.00	\$36. 26	\$36. 26	\$0.00	so. 00	SO. 00
	Subtotals:	2	\$218.00	\$73.46	\$73.45	\$0.00	\$0.00	50. 00
RI. 3. 2 RO	*	1	5166. 00	\$66.51	\$66. 51	\$0.00	\$0.00	\$0.00
	*	1	\$186.00	\$65. 16	\$65. 16	\$0.00	50. 00	\$0.00
	Subtotals:	2	\$372.00	\$131.69	\$131.69	S0. 00	so. 00	S0. 00
R1. 3. 2 R1. 3. 2	*	1	\$186.00	\$04. Y0	\$35. 72	(\$29. 24)	\$0.00	\$29. 24
	*	1	S166. W	\$66.85	\$37. 19	(\$29.66)	\$0.00	\$29.66
	*	1	\$186.00	\$65. 16	\$36. 26	(\$26. 92)	\$0.00	\$28. 92
		1	\$166.00	\$65. 18	\$36. 26	(\$26. 92)	50. 00	\$26. 92
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Findin	gs E	By Code By	, Patiei	nt					
OAS 3M	P	Patient	Units	Chg. Ami	Allowed	Auditedi	Difference	Under	Over
R1. 3. 2 Rl. 3. 2	2 *		1	\$186.00	\$66.65	\$37. 19	(\$29.66)	50. 00	\$29.66
		Subtotals:	5	\$930. 00	\$329.02	\$162.62	(\$146. 46)	so. 00	\$148.40
RI. 4. 2 RO	*		1	\$323. 00	5101. 93	\$101.93	\$0.00	\$0.00	50.00
	*		1	\$304.00	599. 37	\$99. 37	50.00	50.00	so. 00
		Subtotals:	2	\$627.00	6201. 30	\$201.30	\$0.00	50.00	\$0.00
Rl. 4. 2 R2 5	*		1	\$276.00	\$94.36	\$94. 36	50. 00	50. 00	\$0.00
		Subtotals:	1	\$276.00	SD4. 36	\$94.36	so. 00	\$0.00	50. 00
Rl. 4. 3 RO	*		1	\$323.00	\$101.93	5101. 93	50.00	50.00	\$0.00
	*		1	\$323.00	5102.07	\$102.07	\$0.00	\$0.00	50.00
	*		1	\$304.00	\$99.37	\$99.37	\$0.00	\$0.00	\$0.00
			1	\$323.00	\$101.93	\$101.93	\$0.00	\$0.00	\$0.00
	*		1	5304. 00	SDS. 06	SDS. 06	\$0.00	50.00	\$0.00
	*		1	\$276.00	\$94. 36	\$94.36	\$0.00	\$0.00	50.00
			1	₽ JU4.UU	\$99. 37	\$99.37	\$0.00	\$0.00	\$0.00
	*		1	\$276.00	\$94. 36	\$94.36	\$0.00	50.00	\$0.00
		Subtotals:	8	\$2,433.00	\$792.45	\$782.45	\$0.00	\$0.00	\$0.00
Rl. 4. 3 R1. 4. 3	*	_	1	\$304.00	\$99.06	\$64.96	(\$34.10)	\$0.00	\$34.10
		Subtotals:	1	5304.00	\$99.06	\$64.96	(\$34.10)	so.00	\$34. 10
R1. 4. 3 R2. 4. 5	*		1	\$323.00	\$102.07	\$106.32	\$4.25	\$4. 25	\$0.00
		Subtotals:	1	\$323.00	\$102.07	\$106.32	\$4.25	\$4.25	S0. 00
RI. 52 Rl. 5. 3	*		1	5501.00	\$160.32	\$66. 51	(893. 61)	\$0.00	593. 61
		Subtotals:	1	\$501.00	\$150. 32	\$66. 51	(\$93.81)	so. 00	\$93.81
R1. 5. 3 R1. 5. 3	*		1	\$388.00	\$155.90	\$64. 96	090. 94)	so. 00	\$90.94
		Subtotals:	1	\$388.00	\$155. 90	SM 98	(\$90.94)	\$0.00	\$90.94
R1. 5. 4 RO	*		1	\$501.00	\$160. 93	\$160. 93	\$0.00	\$0.00	50. 00
	*		1	\$541.00	\$160.93	\$160.93	\$0.00	\$0.00	50.w
		Subtotals:	2	\$1,002.00	\$321.86	\$321.86	\$0.00	50. 00	50. 00
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Findings By Code By Patient

OAS	3 M	1	Patient	Units	Chg. Am	t Allowe	d Audited	Difference	Under	Ove
R1. 5. 4	Rl . 5. 4	*		1	\$386.00	\$155. 90	599. 06	(\$56.84)	50. w	556. 84
			Subtotals:	1	\$386.00	\$155.90	\$99.06	(\$56.84)	50. 00	\$5664
R13	R13	*		1	\$323.00	\$101.93	\$0.00	(5101.93)	\$0.00	5101.93
				1	\$186.00	\$66.65	\$0.00	(\$86.85)	\$0.00	\$66.65
			Subtotals:	2	\$509.00	\$188. 76	S0. 00	(\$188. 76)	\$0.00	\$168. 78
R13	R15	*		1	\$186.00	\$61.62	\$51.62	so. 00	50. w	\$0.00
			Subtotals:	I	\$186.00	\$81.62	\$61.62	\$0.00	\$0.00	<u>80, 99</u>
R2. 2. 3	R2. 2. 4	*		1	\$109.00	\$37. 19	\$101. 93	\$64.74	\$64.74	50.00
			Subtotals:	1	\$109.00	\$37. 19	\$101.93	\$84.74	\$84.74	so. 00
R6	ALT CP	*		1	\$636.00	\$157.65	\$156.92	(50. 73)	50. w	\$0.73
			Subtotals:	1	\$636.00	\$157.65	\$156.92	(\$0.73)	so. 00	so. 73
R6	R6	*		1	\$80.60	\$13.39	\$0.00	(\$13. 39)	\$0.00	\$13.39
		*		1	\$76.00	\$12.36	\$0.00	(512. 36)	so. 00	\$12. 36
			Subtotals:	2	5158. 60	\$26. 75	S0. 00	(\$25.75)	so. 00	\$25.75
		(Grand Totals:	5 4	\$16,351.60	\$5,366.15	\$4,817.79	(\$548.36)	\$68.99	\$617.35

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Page 3 of 3 O 1996, Hwat, Inier, Oct. Biount. P.C

ited Difference	556.84	hx. Detailed history. high	535.72 829.24	5		history. xadol, demerol,	t64.96 834.10	e would agree to	\$99.06 \$0.00	pert Past.) No	561.62 50.00	dent's assessment,	Page 1 of II
Audited	168	th: Swelling right hand (location), over last 2 weeks (duration), intermittant (tining) fever. Felt sick (signs). ROS: Nausea/vomiting. diarrhea, urinary symptoms. Pert past hx. Detailed history. Exam Const, HEENT, Neck, CVS. Lungs. Abdomen/rectal, Neurological Defalled-seven systems MDM Congestive heart failure. Tule-out sepsis (acute life threatening condition-high) hata review. Discussun with family physician, decision to admit, labs, xrays. Overall high	Exam would be considered comprehensive under 99285 guidelines for appropriate exam Medical decision making is high complexity. History is detailed. * 99282 09/07/1995 8186.00 \$64.96 R1.3.2 R1.3.2 99282			hs: Severe pain (quality), both knees, left hip (location), HIV+ (modifying factor), has now onset (duration) [LS (Ext hpl) ROS: musculoskobetal, const. Pert past. Detailed history. MAM Acute condition with mid progression (Full blown HIV with sudden onset of arthraigh both knees) Limited data (Hab and X73y), treatment with multiple HM meds (Toradol, demerol, phenegran) Overall underate.	t6	Dictation could not be located for our review. Reviewer also acknowledged dictation not available and allowed a 99283. Since there is not a documented physical exam we would agree to	6\$	Has: Twitching (CC) Neck and Shoulders (location), pain (signs and symptoms) chronic (quality) infermiffent (fiming), no numbness (ROS). electrolyte disturbance in past (pert Past.) No chest pain (ROS) betailed. Exam Corst Langs dear, heart- NSR. Abdornen benign and BS +, Extremity, musculoskeletal. (betailed).		Government states presence not supported. Attending presence is supported under the pre-July 96 rules. Attending physician per nursing record assigned final diagnosis of cyanosis. Which was not specified in resident's assessment, demonstrating participation in the patient's care. The attending physician signed the emergency treatment record and ordered the discharge.	
8v Aud CPT	99284	vomiting, diarr physician, de	gh complexity. 99282	remities (location).w/o relief from cream (modifying factor) ROS: Allergies none. EPF history. d illness). Treatment: Decadron IM (underate) Overall low.		hpi) ROS: musc a (tab and xray)	53283	. Since there i	99284	numbness (ROS	data igyeweg (labs, limited) Cyerali incoerate. R15 99283	ignosis of cyam rdered the dis	
CPT CD R	RI . 5. 4	ROS: Nausea/	making is hig R1.3.2	ROS: Allergles	5	cion) ILS (Ext s) Limited data	R1.4.3	slowed a 99283	R0	ent (timing), no	ievieweu (Tabs R15	signed final dia record क्राप्त o	
Jroup Allowed Reviewers (1)	8155. 96 Rt. 5. 4	sick (signs). systems wiew: Diicuss	um Medical decision \$64.96 R1.3.2	difying factor)		onset (durat ka both knees	R1.4.3	tilable and 8	6 R1.4.3	Jality) intermittal.	erate), data 2 R13	ing record ass ncy treatment	
Grou	\$155.96	fever. Felt Illed- seven ithly) Data re	ate exam Med \$64.96	om cream (mod adron IM (moder		rctor), has new systems. et of arthralg	899. 06	Mation not ava	899. 06	is) chronic (qu musculoskelet	43 given (moder 861.82	cian per NUIS id the emerg <i>e</i> r	
Tealcal Charge Amt	\$366.06	mittant (timing) rotogical. Dete ening condition	for appropri	Joh.).w/o relief from cream (modifying factor) Treatment: Decadron IM (moderate) Overall		(mdifying fa eurological ch sudden ons	\$364.66	knowledged dik	\$304.00	s and sympton +, Extremity,	\$186.00	ending physi ysician signe	
are IV	03/05/1995	eeks (duration), inten domen/rectal, Neur i (acute life threate	· 99285 guidelines 09/07/1995	extremities (location m cated illness). Tr		nip (location), HIV+ musculoskeletal, n ul I blown HIV wit	10/14/1995	Reviewer also ac	10/29/1995	cion). pain (signs and symptoms) chronic (quality) infermitten nen benign and BS+, Extremity, musculoskeletal. (Detailed).	M.CH. M.1d exacerus 01/24/1996	eJuly 96 rules. Att The attending ph	
Community Orgent C Patient Name CPT Code	99265	M), over last 2 W CVS. Lungs. Ab re. rul o o ut sepsis	nprehensive under 99283	Hx. as above: Rash all over (quality). both extremilies (local Exam skin both legs, constitutional, EFF exam MDM: Acute allergic reaction (a new momplicated illness).	from 5 to 3	hx: Severe pain (quality), both knees, left hip Exam EPF exam of extremity covering (ski"), m NMM Acute condition with mid progression (Full phenegran) Overall underate.	99264	l for our review. n.	99264	witching (CC) Neck and shoulders (location pain (ROS) Detailed. Corst. Lungs dear, heart- NSR. Abdomen	M. Linvoluncary CM. CCH.ng. (CHronic provedit M. 4 99283	not supported. rted under the pr the patient's care.	
IMUNILY Patient Name	*	ght hand (locatio HEENT, Neck, '@ heart failur	e considered com *	Rash all over both legs, const ultergic reaction	Reviewer downcoded service from 5 to 3	hx: Severe pain (quality), both Exam EPF exam of extremity (MDM Acute condition with mil- phenegran) Overall underate.	99283 based On exam *	Dictation could not be located yield to the reviewers decion.	*	Hx: Twitching (CC) Neck and Chest pain (ROS) Detailed. Exam COYSt. Lungs dear, he	tary twitching	Government states presence not supported. Attending presence is supported under the demonstrating participation In the patient's car	Thursday, May 31.2001

			Jan and an annual and a	J					
Patient Name	CPT Code	Date Chi	Date Charge Amt.	Allowed Reviewers CD CPT CD Rev	ers CD CP	T CD Rev	Aud CPT	Audited	Difference
*	99264	02/05/1996	\$276.60	t94.36 RI	R1. 4. 2 R	R25	66265	594. 36	\$0.00
Reviewer used psych consult as record reviewed. This History would be waived due to patient's delusional st constitute a comprehensive singel system psych. Ba treated initially with Haldol (high risk medication), ac implied to be a level 5 service.	as record review to patient's defus singel system ps igh risk medicati	ed. This is not the ED record. sional status. It appears from yet. Based on documentation i.ion), accompanied to floor by i.	ED record. ppears from the infentation in the to floor by ED sta	discharge summer nursing records t M. If this record v	y that a co he patient w were treated	mplete mental as placed In 1 by the revie	Reviewer used psych consult as record reviewed. This is not the ED record. History would be waived due to patient's delusional status. It appears from the discharge summary that a complète mental status examination was performed in the ED. This would constitute a comprehensive single system psych. Based on documentation in the nurshing records the patient was placed in restraints (at risk for harm to self or others), hill complexity, threaded initially with Haldon (high risk medication), accompanied to floor by ED staff. If this record were treated by the reviewer in the same way as record 91, ** The service would be implied to be a level 5 service.	e ED. This wo hers), hiih com e the servie	uid nplexity, ce would be
*	63284	02/24/1996	5276.00	\$94.36 RI	R1. 4. 3 R	RO	66264	594.36	S0. 00
Hx: 1 month (duration), sharp (quality), left apical (location), radiating to left shoulder (signs), Spast and social. Detailed history. Exam: Detailed, heart, 1 ungs. abdomny. MDM: Acute condition posing threat [o (quality), teft as long. ony. threat [] iffe	pical (location), radi: 9 (angina),moderate	ating to left show data:(labs, EKC, XX	ulder (signs), SOI av) : Moderate	3 on exertik	эл (context). E	cation), radiating _{to} left shoulder (signs), SOB on exertion (context). Ext HPI. ROS: NV (GI), Chilis (const), cough (resp) Ext ROS. Pert a),moderate data:(labs, s.ss., xray) , Moderate	gh (resp) Ext l	ROS. Pert
*	66282	04/24/1996	\$109.00	\$33.42 RO	24	RO	88282	\$33.42	\$0.00
* Reviewer downcoded from 4 to 3	88284 to 3	981/81/20	\$278.00	\$94. 36 RI	RI. 4. 3	2	68284	894. 36	80.00
Hx: MVA (modifying factor), bit car head on (context), pain(sign) In neck, right ches medical history. Detailed history, and medical history in the context of the context	t Cal head on (c lory. it, lungs, abdor s. ekg. Acute co	context), pain(sign) In men, and extremities molicated injury (n neck. right cher j- detailed exam chest contusion.	st and RUQ (locat	ion). EXT h	pl. Ext ROS-	pain(sign) In neck. right chest and RUQ (occation), EXT hpl. EXt ROS-Pert (not uprtight orwalking at seen), Allergies none. Past dextremities detailed exam destremities detailed exam defient having order occan had surnery) Overall moderate.	Allergies none.	Past
*	88284	05/22/1996	\$276.00	894.36 RO	×	RO	99284	\$94.36	\$0.00
Hx: 2 day No (duration), LUQ abdominal pain (tocatio Diarthea (GI). Extended. Pert past (meds) Defailed. Exam: Const. Eyes, ears, neck. chest, heart, abdom MDM. Acute condition with mild exacerbation (diver Overall moderale.	abdominal pain t past (meds) E ck. chest, hearl mild exacerbatio	(location), per para)etailed. L, abdomen, neuro, n (diverticulitis with	medic hx, pt c/o l extremities, Detai chest pain), Multi	burning pain (qua) Hed exam or com iphe data: Labb, (ity), no dys prehensive skg, xrays.	pnea a diaph single system Multiple media	Hx: 2 day No (duration), LUQ abdominal pain (location), per paramedic hx, pt do burning pain (quality), no dyspnea a diaphoresis (signs). Ext IBT. ROS: cough (resp), fever (const), Diarthea (GI). Extended. Pert past (meds) Detailed. Exam: Const. Eyes, ears, neck. chest, heart, abdomen, neuro, extremities, Detailed exam or comprehensive single system cardiac exam. MDM: Acute condition with mild exacerbation (diverticultits with chest pain), Multiple data: labs, ekg, xrays. Multiple medications: vloodin, bactrim, flagyri. Discussion with family physician.	p), fever (con	ist), ohysician.
Thursday, May 31, 2001									Page 2 of 11
Confidential Medical Record									• •

Patient Name CPT Code Date Charge Amt. Allowed Reviewers CD CPT CD Rev Aud CPT	10/06/1996 \$278.00 \$94.36 R0 R0 99284 \$94.36	inc. severe (quality) back pain (location) for two days (duration), releved with pain meds at home (modifying factor) Ext hpi, ROS: Constitutional (fever), osteomyelitis (musculoskeletal), sickle cell (femaniological) Ext ROS. Past history, social. Detailed history. Exam: Constitutional proof does, CV, addomen, externity, (detailed-5 areas) ROM: Acute illness with severe progression accordation (sickle cell crisis-high), treatment IV pain meds and need for admission for parameter therapy (high). Overall high community	10/11/1996 \$276.00 \$94.38 R0 R0 99284 \$94.36 \$94.36	OAS agreed to accept this as a 99284. cc: Fall, pain low back, right knee and mid criest (location), stumbled over heating pad (context), broke fall with hands (modifying factor), worried about right knee (sign). Ext hpi. ROS: dizziness (neuro). CP (CV), Headache (const)- Ext ROS. Pertinent past and social. Detailed history. Exam: Constitutional. Eyes, ENT, Resp, CV, Musculoskeletial, Psych (alert and cooperative). Detailed exam. MDM. Acuse complicated right? Fall with contaston, arrived by ambulance), limited data (xray), moderate risk-patient on medication requiring monitoring (coumadin, used in decision making for medication management and treatment options). Overall moderate	11/08/1996 \$278.00 \$94.36 R0 R0 99284 \$94.36	Hx: Duration (orgoing 2 weeks), quality (increasing SOB), Tongue swelling (signs), modifying factor (pessary in place). Extended ROS: Allergies, GU (diff voiding), GI (neg n.v.d)- Extended. Evam: Constitutional (alert), Lungs: clear, CV; SS, no mumurs. Abdomen, Skin and ENT. Defauled exam. MDM, Abdomen, skin and ENT. Defauled exam. Skin and ENT. I clearly increasing SOB), discussion with other physicians (GYN resident called, family physician called), interventions: foley cath, IV solumedrol (IV with additives) Moderate	01/07/1997 \$304.00 \$99.37 R1.4.3 R0 99284 \$99.37	hx: back(location) pain since last night (duration), given nx for vicodin but did not have it filled (modifying factor), has hed right buttock pain since bumping it on a table (context). Ext Hpi. ROS. Altergies none, no uninary or bowel incombinence (Ext ROS), Pert past. Detailed history. Exam: Corast, HEENT, Luugs, Back, Aruco (Ostatiled exam). MDM: Pneumonia and back pain. (chronic filters combined with new acute illness) discussion with family physician. Moderate presenting problem. Treatment: Vicodin and flu with family physician. (moderate for Rx meds).	01/27/1997 \$76.00 \$12.36 R6 R6	physicians treatment record.	
Patient Name CPT Code	99284	hx: severe (quality) back pain (location) for two days (duration), relieved v sicke cell (homatological) Ext ROS. Past history, social. Detailed history, social. Detailed history. Martin Constitutional, chest, CV, abdomen, extremity, (detailed-5 areas) MDM: Acute illness with severe progression, assacentation (sickle cell trigils).	99284	OAS agreed to accept this as a 99284. cc: Fall, pain low back, right knee and mid che dizziness (neuro), CP (CV), Headache (const). Exam: Constitutional, Eyes, ENT, Resp, CV, M. MMH. Acute complicated injury (Fall with cheedediscion making for medication management to	* 99284	Hx: Duration (ongoing 2 weeks), quality (increasing SOB), Tong Pert past, (Detailed hx) Exam: Constitutional (alert), Lungs: clear, CV; SS, no murmurs. Abdomen, Skin and Ent. Detailed exam. MDM, Audie illness with progression (alergic reaction with incresolumedrol.(IV with additives) Moderate	99284	hx: back(location) pain since last night (duration), given rx for vicodin but t ROS: Allergies none, no unnary or bowel incontinence (Ext ROS), Pert patent corest, HEENT, Lungs, Back, neuro (locatied exam) MOM: Preturnoria and back pain. (dhronfc illness combined with new acu Treatment: Vicodin and f/u with family physician. (moderate for Rx meds)	93010	Cannot find support for EKG ϕ terpretation ϕ the physicians treatment record.	Ihursday, May 31, 2001

	\$0.00	verity).	00.0\$	dreses	So. 00	80.00	story. ansfer	\$28.92		Page 4 of 11
		2/10 (se	b	sheet ad ata: πυί	m	_	tailed hi			Page
halita	Auduea 8156.92	bsided to isive.	5166.92	et. Pink tensive d	\$65.18	899.37	Past- der lan. decis	836.26		
		chest pressure subsided to 2/10 (severity), y, social. Comprehensive.		see pink sheet. Pink sheet addreses hearl rale. Extensive data: multiple		moderate	const. Pert ary physid			
		chest pr y, social.				^{ng} hx. Keflex given (Rx meds), Overall underate 99284	GU. GI. o			
		ymptoms). ast. famil sicians.	20	Complete to obtain), thensive e		(Rx meds	hpl. ROS: liscussion			
ray Park	99285	ns and s 99285.) P.	99265	Exthpi. Is difficult r. (compre pleural e	99263	hx. efflex given 99284	gns) Ext litives, d	99202		
	-	resis (sig elines for s	0	g factor) at history llovascular cenia with	•	nent, EPF aced), Ke	wering (si v with add			
	02 O2	nd diapho AM guid six discus	æ	ic (modifyin tenent th , and carc combocyto;	RO	ve replacer sutures pl	of and shatners: I	R1. 3. 2		
	RO	pitations a settle under am).	Q). atcohol ralifying st: eyes. ent ce and th	RO	fix Post val ocaine, no Ro	timing), fer : xray. Tre	1.3.2	Overall low	
dno	Aughea Keprepers CD CF1 CD Kep 8156.92 R0 R0	SOB. pal ered comp iscular ex	\$156.92 RO	c (quality 480 has qu mentary, tis, jaundi	\$65.18	(location), no pebloc pain (pert ROS) Past bx Post valve replacement EPF hx, stremities. Detailed. Completed for plant with allengy to lidocaine, no subures placed). Keflo OS/09/1997 \$304.00 \$99.37 Ro R0	ality and ed exa m. ekg. chest	\$65.18 RI.3.2	derate. (
7		fty), assoc be consid m cardiovs	s 00	spirophasi istory. (a ny, integu with hepati complexity		(pert RC with allo	Menting (qui al. Detall a: labs,		es. madryl) М	
edica	Cnarge Ami.	iffed (qual his would gle syste th risk: trea	8472.00	pain is re ehensive h , respirate ssociated v	\$188.00	no pelvic pain Detailed. injury- patient 37 \$304.00	M this ev and rect Liftiple dat	\$186.00	n both ey OX, and DE	
e M	198	eally intens to treat, t ensive sim	03/12/1997	(location), y. Compruioskeletal coloskeletal coloskeletal	04/08/1997	ocation), no remities. Det omplicated inju 05/09/1997	out 4-5 P odremities, Wement, M	07/19/1997	ng with history. d follkular exan dications (diam	
Car	Date Da	ion), gradu o urgency (Comprehist pain, ric	03/	rant pain iily histor cal, musco ation (alco	9	and (locating extremion (complete)	irse at ab back, e ternic invol	.//20	conting Wi	
gent	UTI COME 9265	tion, locati V (Due to Neuro	99285	pper quadristory, fam yschologia r exacerb ddithres.De	99203	ised right h abdomen ar tdon to han 99264	ration), wo t, abdonen	99203	not forth conjuncțiv (low), two	
	99265	AM (dural esp, GU,C ENT, CV.	5	ns), right u medical † clogical, p vith sever IV with ac	6	ext). bruis heart. and kacerath	e 2 am (du hest, hear ule illness	eń.	atient is focused- illness	
Community Urgent C	rame *	Hx: chest pressure since 7 AM (duration, location), gradually intensified (quality), assec 508. pelpitations and diaphoresis (signs and symptoms), chest pressure subsided to 21/1 Ext HPI. ROS: Const, Gl, resp. GU,CV (Due to urgency to treat, this would be considered complete under AM guidelines for 98285.) Past. family, social. Comprehensive single system candiovacation social social social control in the control of the co		Hx. cough, fever, chilis (signs), night upper quadrant pain (location), pain is respirophasic (quality). sicoholic(modifying factor). Ext hpi. Complete NOS: see pink sheet. Pink sheet address teast least (by systems. Past medical history, family history. Comprehensive history. (also has qualifying statement that history is difficult to obtain). Exam Constitutional in neurological, prachological, musculoskelal, respiratory, integumentary, eyes. ent, and cardiovascular. (comprehensive exam). MBM Chronic condition with sweer exacerbation (alcoholism associated with hepatifis, jaundice and thrombocytopenia with pleural effusion, elevated hear rale. Extensive data: multiple labs. Krays. Treated with IV with additives. Decision to admit. Overall high complexity.	*	hx: Injoyed and fell (context). bruised right hand (location). Exam: Const. back. chest, heart. abdomen and extremities. MDM: cortusion on back and lacentibor to hand. (complexage). * 99264 05/09/19	hx: back pain (location) since 2 am (duration), worse at about 4.5 PM this evening (quality and timing), fever and shwering (signs) Exthpl. ROS: GU. GU. const. Pert Past-detailed history. EXT, neck, chest, heart, abdomen. back, extremities, and rectal. Detailed exam. Whis-Presenting problem: sould illness with systemic involvement, Multiple data: labs, edg. chest xray. Treatment: IV with additives, discussion with primary physidan. decision to transfer for admission. Molerate	*	History should be wiaved. Patient is not forthcoming with history. Exam Expanded problem focused- conjunctiva and folkcular exam both eyes. MDM Acute uncomplicated illness (fow), two medications (diamox, and benadryl) Moderate. Overall low	31, 2001 cord
mm	* *	st pressur . ROS: C. Const, res	*	gh, fever, 140 syste Constitution ronic co	77	ped and f Const. bar contusion	hx: back pain (location) shx Exam: Eyes. EMT, neck, v MDM:Presenting problem: a for adni ssi on. Moterate	ጥ	should be Expanded cute unco	Thursday, May 31, 2001 Confedental Medical Record

## 99202 O7721/1957 \$109.00 \$25.25 R1.2.1 No. 1962.20 992.20 S8.2.2 R1.2.1 No. 1962.20 992.20 S8.2.3 S8.2.0	### 99262 O731/1997 \$109.00 \$36.26 R12.1 R0 992.32 ### 99293 O731/1997 \$10.00 \$100.00	
** 99262 Official will be gotted (combod) Miltry the paramet. Inche Sunglasses (modifying factor). To be (port MSO) Laceration right eyelvow (location), Ends by: Extractly and interpolated by the paramet. Inches Sunglasses (modifying factor). To be (port MSO) Laceration right eyelvow (location), Ends by: Extractly and the parameter of properties of of	## 99282 0773/1997 \$109.00 \$35.26 R12.1 RD 992.32 Richard Willing outside (context) hilling the paramete, brade Sunglasses (modifying factor). To be (port RES). Laceration right cycleron (location). Brid lipi: Extend RIC May and context adheren be build in story: Payes, Eff. C. Resp. mock, adheren be builded. Payes and the context adheren be builded. Payes and the context adheren be builded. ** 99293 mock adheren be builded. ** 99299 mock adheren be builded. ** 99299 Moration), adheren and proceed history of hypertension (low), breaked with cover-the-count let dougs-polyspoin. Brad righty with laceration, needed by the context of the context of hypertension (low), breaked of the context of the context of hypertension (low), breaked and the confident with rever exacerbellosing (low) and context of the confident of the context of the confident of the context of the confident of the confidence of the conf	
The strict willing outside (control) billing the pavement, horder Sourgiasses (modifying fractor). No he (perf BNS). Laceration right eyekrow (location), Bild bills the pavement, horder Sourgiasses (modifying fractor). No he (perf BNS) is carretion right eyekrow (location). Bild billing with history of hypotheristics (modifying fractor). Patient had an accute uncomplicated billing with history of hypotheristics (modifying fractor). Patient had an accute uncomplicated billing with history of hypotheristics (modifying fractor). * 99293 6972411997 \$472.00 \$156.92 BO BO 99299 81299	Firstent walking outside (context) Hilling the parvement, bruke Simplasses (modifying factor). No be (perf RBS). Laceration right eyehrow (location), Brief hip. Extend cliff masobolosheled Fort Past. Expanded problem focased history. Patyess, EM1 Cr. Resp, nect., advance. Patyess, EM1 Resp, Cr. Gl. Masochosteledi. Stin. (comprehensive maltisystem committee.) Patyess, EM1 Resp, Cr. Gl. Masochosteledi. Stin. (comprehensive maltisystem committee.) Patyess, EM1 Resp, Cr. Gl. Masochosteledi. Stin. (comprehensive maltisystem committee.) Patyess, EM1 Resp, Cr. Gl. Masochosteledi. Stin. (comprehensive maltisystem committee.) Patyess, EM1 Resp, Cr. Gl. Masochosteledi. Stin. and Neurobogocal. Comprehensive Exam. Chronic Lilmess with severe exactractation (exophagoed spans with a near synchogocal decode cocurring during treatment). moderate data (labs., edg. xrays), Discusses and severe exactractation (exophagoed spans with a near synchogocal decode cocurring during treatment). moderate data (labs., edg. xrays), Discusses and severe exactractation and left side cheet pain (location). [registending with including. Patyess, EM1, neck. Imags. Cr. Resp, accordance and neck. Path Resp. Resp. Activity. Patyess, EM1, neck. Imags. Cr. Resp. R	
May Patient and an acte uncomplicated play with history of hypertension (low), besided with over-the-coan for dage-polysporin. Head fighty with Laceration, needed to follows any other highers of the programment of the prog	These, RMI, CY. Mosty, next, adomen. Detailed. * 99293 0972411997 \$472.00 \$166.92 NO NO 99299 * Patient had an acute uncomplicated injury with history of hypothension (504), brealed with over-the-coun let drugs- polysporin. Head injury with lacenation, aceded recomplicated injury with history of the patient had an acute uncomplicated injury with history of the patient had an acute uncomplicated injury with history of the patient had an acute uncomplicated injury with history (duration), and officulty and foreign to his back (quality), nauseabed (signs) Ext hp. RNS complete. Past, family and social. Comprehensive canal. Acute condition with service exactbation (pancreaditis, sortic aneurysm, rule-out dissection/urplure). Extensive data: labe, edg. xrays, CTS, decision to admit (on a condition with service exactbation (pancreaditis, sortic aneurysm, rule-out dissection/urplure). Extensive data: labe, edg. xrays, CTS, decision to admit (on the patient of the patient	Extended ROS- respiratory
** 99293 (Gurallon), addominal path (location), raddating to his back (quality), nausaated (signs) Ext hpi Ris complete. Past, family and social. Comprehensive history.] 11. Chart. Eyes, EMT, Resp. Cr. Gil, Mesculosisdeled, Skin, and complete are cand. 12. Chart. Eyes, EMT, Resp. Cr. Gil, Mesculosisdeled, Skin, and complete are cand. 13. State condition with reveree accardation (partradity, sortic aneutys). Tallists to a state of control selection (partradity) and confident with reveree accardation (partradity) and confident with reveree accardation (partradity). 13. State condition with reveree accardation (partradity) and confident are cand. 14. State condition with reveree accardation (partradity). State (control selection) and confident are confident and confident are cand. 15. State confident are confident and confident are cand. 16. Chronic Illiness with severe cacadration (sepachageal spasa with a mest stronged specied cocarding during treatment). Moderate plan (control selection). Selection to admit t. treatment with IV mede high complexity. 16. State cand. State cacadration (sepachageal spasa with a mest stronged specied cocarding during treatment). Moderate plan (cocardation). Selection to admit t. treatment with IV mede high complexity. 17. State cand. State cacadration (sepachageal spasa with systemic symptome. Institute to a selection to admit t. treatment with Vinester plan (cocardation). Selection to admit to admit the cacadratic symptome. Institution to admit the cacadratic symptome. Institution (selection). Selection to admit the cacadratic symptome. Institution of selection to admit the cacadratic symptome institution to admit the cacadratic symptome institution of selection to admit the cacadratic symptome institution of selection to admit the cacadratic symptome institution of selection to admit symmetric symptome. Institution of selection to admi	** 99293 0972411997 \$472.00 \$166.92 R0 R0 99299 stay history (duration), advantal pain (location), radiating to his back (quality), nausaaled (signs) Ext hip. RIS complete. Place, (c) Muculoskeletal, Skin (comprehensive multisystem exam) Acute condition with reference exacerbation (pancaelifits, and comprehensive multisystem exam) Acute condition with reference exacerbation (pancaelifits, and comprehensive multisystem exam) Since July (duration) pain in meck (location), feeling like this stuck (context). Slight choking sensation (quality), and difficulty breathing (signs) Ext HP). RIS: of Constitutional, pages, ENT. Rasp. CV. Musculoskeletal, Skin, and Neurological. Comprehensive Exam. Chronistutional, gives, ENT. Rasp. CV. Musculoskeletal, Skin, and Neurological. Comprehensive Exam. Chronistutional, gives, ENT. Rasp. CV. Musculoskeletal, Skin, and Neurological. Comprehensive Exam. Chronistutional, gives, ENT. Rasp. CV. Musculoskeletal, Skin, and Neurological. Comprehensive Exam. Chronistutional, gives, ENT. Rasp. CV. Musculoskeletal, Skin, and Neurological. Comprehensive Exam. Chronistutional, gives, ENT. Rasp. CV. Musculoskeletal, Skin, and Neurological. Comprehensive Exam. Chronistutional, gives, ENT. Rasp. CV. Musculoskeletal, Skin, and Neurological Comprehensive Exam. ** 99284 08/30/1997 \$304.00 \$993.37 R1.4.2 R0 \$99264 ** 99284 08/30/1997 \$304.00 \$999.37 R1.4.3 R0 \$99264 ** 99284 09/20/1997 \$304.00 \$999.37 R1.	needed to rul e o ut any oth
it Const. [Feet, EMT, Resp., Ct. Gt. Musculosteledel, Skin (comprehensive mality); nauseated (signs) Ext hpt. RIS compete, Past., family and social. Comprehensive history. Acute condition with severe exacebation (panceating, social aneurysm, rule-out dissection/tupture). Extensive data: labs, ckg. xrays, CTs, decision to admit (overall high competalty). Acute condition with severe exacebation (panceating, social aneurysm, rule-out dissection/tupture). Extensive data: labs, ckg. xrays, CTs, decision to admit (overall high competalty). In Constitution, pain in med (location), feeling 11the this studk (centext). slight choking sensation (quality), and difficulty hereathing (signs) Ext HPl. RIS: Comprehensive, Past., and Social Comprehensive Exam. In Constitution, pain in med (location), feeling 11the this studk (centext). slight choking sensation (quality), and difficulty hereathing (signs) Ext HPl. RIS: Comprehensive, Past., and Social Comprehensive Exam. In Constitution (social page) RIM: A. Disc. A. Disc. Comprehensive Exam. In Constitution and left side cheet pain (location). Feel in Fressure sensation (quality), decreased opposite (signs), pain worse when she eats (modifying 1spect), and CRS. Adomen. Feeld, social land fundly. Retailed is social comprehensive Exam. In Constitution (and the complete of Camparity) and CRS. Adomen. Feeld, scrivenity and feelor. Retailed elsoy. In constitution of Comprehensive Exam. A. 99284 (09/20/1997 \$304.00 \$999.37 R14.3 RIO 99284 (signs). Ext HPl, RIS: Resp. corrst. Gl. Past Camparity (constitution) and feet in the companion of the companion of signs). Ext HPl, RIS: Resp. corrst. Gl. Past Camparity (constitution) and respect to the constitution of Rights) (volumentation). Feet side distory. Constitution of Constitution of Rights) (volumentation). Feet side distory. Decarding to reflux had sinilar condition with mind progression (constitution) and respect to the signs of signs). Ext HPl, RIS: Resp. corrst. Gl. Past Richard Richard Richard Richard Richard Richard Ric	stay history (duration), abdominal pain (location), radiating to his back (quality), nauseated (signs) Ext hp. RIS complete. Past, family and social. Comprehensive mitraystem exam. Acute condition with severe exacerbation (pancrealities, and the analysm, nulse-out dissection/upture). Extensive detail labs, ekg. xrays, CTS, decision to admit (on a social. Comprehensive history. Acute condition with severe exacerbation (pancrealities, and the analysm, nulse-out dissection/upture). Extensive detail labs, ekg. xrays, CTS, decision to admit (on a social. Comprehensive history. In Constitutional, lays, and social. Comprehensive history. In Constitutional, pain in nect (location), feeling like this stuck (Context). Slight choking sensation (quality), and difficulty breathing (signs) Ext HPI, RISS; (ligns). Ext HPI, RISS; (Context). In Constitutional, lays, and such a server exacerbation (escophaged spassus with a social. Comprehensive Exam. A 99284 OBJ3041997 \$304.00 \$99.37 RI.4.2 RIO 99264 OBJ3041997 \$304.00 \$99.37 RI.4.2 RIO 99264 OBJ3041997 \$304.00 \$99.37 RI.4.3 RIO 99264 OBJ2041997 \$304.00 \$99.37 RI.4.3 RIO 99264 Extraction in liness with systemic symptomer inability to eat), additional with including: In the data: EM, labs, xrays, (underrite) The data: EM, labs, xrays, (underrite) A 99284 OBJ2041997 \$304.00 \$99.37 RI.4.3 RIO 99264 Patient arrived by ambudance. Coughing, without hemophysis (respRROS), clo chest pain (focation), stopped on and off (liming), SOB (signs). Ext HPI, RIOS; Resp., Example of signs). Ext HPI, RIOS; Resp., Example of signs, cry. Decision bisions.	
Since July (duration), pain in meck (location), feeling like this stuck (context). Slight choking sensation (quality), and difficulty breathing (signs) Ext HPI. MSS. Comprehensive. Past., I yand social. Comprehensive below. Chronic illness with severe exacerbation (esophageal spasm with a near synopole episcole cooling during treatment). moderate data (labs. efig. xajys), Discussions with multiple distance. Chronic illness with severe exacerbation (esophageal spasm with a near synopole episcole cooling during treatment). moderate data (labs. efig. xajys), Discussions with multiple severe exacerbation (esophageal spasm with a near synopole episcole cooling during treatment). moderate data (labs. efig. xajys), Discussions with multiple severe exacerbation (esophageal spasm with a near synopole episcole cooling during treatment). moderate (signs) pain worse when she eats (modifying seve. EMT, mack. I unays. CMS. Andomen. Tedal. extremity and rearo. Detail of exam. I Adominated by ambidance. Coughing, without hemophysis (respROS), clo cless pain (location), stopped on and off (fining). Sob (signs). Ext HPI, MNS: Resp. cornst. GI. Past and social history. Defailed history. I Coret, Eyes. ett. Resp. CY. skin and neuro. (Detailed). I All mines condition with mile propression (coughing secondary to reflux, had similar condition with mile propression (coughing secondary with management (addition of Regign). Overall molecute. I condition with mile propression (coughing secondary to reflux, had similar condition with mile propression (coughing secondary with management (addition of Regign). Overall molecute. I condition with mile propression (coughing secondary to reflux, had similar condition with mile propression). I consider with mile propression of example	** 99295 0924/1997 s.472.w \$156.92 RO RO 99295 Since July (duration). pain in neck (location), feeling 1 like this struck (Context). slight choking sensation (quality), and difficulty breathing (signs) Ext HPl. ROS: (Unrould Jees, ENT. Rasp. CY. Musculoskedelal, Skhi. and Neurological. Comprehensive Exam. Chronic 11 liness with severe exacerbation (cooperageal spassm with a near syncopal episode occurring during treatment). moderate data (labs, ekg, xrays), Discussion in the series exacerbation (cooperageal spassm with a near syncopal episode occurring during treatment). moderate data (labs, ekg, xrays), Discussion in the series exacerbation (cooperageal spassm with a near syncopal episode occurring during treatment). moderate data (labs, ekg, xrays), Discussion of Sec. Sec. Sec. Sec. Sec. Sec. Sec. Sec.	hensive history.! it (overall high complexit)
d difficulty breathing (signs) Ext HPI. RUS: Comprehensive, P. moderate data (labs, ekg. xrays), Discussions with multi 99264 899.37 exreased uppedie (signs). pain worse when she eats (modifyir exreased uppedie (signs). Ext HPI, RUS: Resp, const, Gi. Past iming), SOB (signs). Ext HPI, RUS: Resp, const, Gi. Past and comparison of Ext to old EXG (no new changes com	is and social. Comprehensive history. If and social comprehensive history. If and social comprehensive history. If and social comprehensive history. Constitution, pain in neck (location), feeling like this stuck (context). slight choking sensation (quality), and difficulty breathing (signs) EX HP). ROS: Constitution is severe exacerbation (escophageal spasm with a near syncopial escode occurring during treatment). moderate data (labs, ekg, xays), Discuss ticks and the severe exacerbation (escophageal spasm with a near syncopial escode occurring during treatment). moderate data (labs, ekg, xays), Discuss ticks and the severe exacerbation (escophageal spasm with a near syncopial escophageal spasm with some recognition of the story. Since it is social and family. Detail ed is story. Exponsibility is social and code. A shakeman, rectal contains and code. A shakeman, rectal code and social is story. Detailed history. Base and social in story. Detailed history. R14.3 R0 99264 R14.3 R0 99264 R14.3 R0 99264 R14.9 R0 89264 R14.9 R0 89264 R14.9 R0 89264 R14.9 R0 89264	\$156.92
99264 899.37 99264 899.37 99264 899.37 iming), SOB (signs). Ext HPI, NOS: Resp, const, Gi. Past and comparison of End to old ENG (no new changes con	* 99284 08/30/1997 \$304.00 \$99.37 RI.4.2 RO 99264 The week (durabon), left sided abdominal and left side cheet pain (location). Feels like pressure sersation (quality), decreased uppute (signs), pain worse when sind in the cyes, ENT, neck. lungs. CNS. Abdomen, FeCtal and family. Detailed bistory. The constraint information of the control of the co	Jiscussions with multiple
ecreased uppelie (signs). pain worse when she eats (modifying) 59264 899.37 197 1986, const., Gl. Past and comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. to old Exc. (no new changes common comparison of Exc. (no new changes common companison c	week (duration), left sided abdominal and left side chest pain (location). feels like pressure sensation (quality), decreased appear (signs), pain worse when sings. Gl. const. respirationly and CNS. Pert past, social and family. Detailed history. 15. Most const. respiration and CNS. Pert past, social and family. Detailed history. 15. Addominal pain, unknown ebbogy. Additional extremity and neuro. Detailed exam. 15. Addominal pain, unknown ebbogy. (Additional extremity and neuro. Detailed exam.). 16. Addominal pain, unknown ebbogy. (Additional extremity and neuro. Detailed exam.). 17. Addominal pain, unknown ebbogy. (Additional extremity and neuro. Detailed exam.). 18. Addominal pain, unknown ebbogy. (Additional extremity and neuro.). 18. Addominal metail. 18. Addominal metail. 18. Addominal metailed.	
99264 899.37 off (liming), SOB (signs). Ext HPI, MOS: Resp, const, Gi. Past review and comparison of EMC to old EMG (no new changes com	* 99284 09/23/1997 \$304.00 s99.37 R1.4.3 R0 99264 about amived by ambulance. Couphing, without hemophysis (respROS), cto chest pain (location), stopped on and off (liming), sob (signs). Ext HPI, mos: Resp, cal aand social history. Detailed history.	hen she eats (modifying
Patient arrived by ambulance. Coughing, without hemoptysis (respROS), clo chest pain (location), stopped on and off (liming), SOB (signs). Ext HPI, MOS: Resp, const, Gl. Past Ical aand social history. In Const, Isass, eff., Resp., Cr. skin and neuro. (betailed). In Const, Isass, eff., Resp., Cr. skin and neuro. (betailed). In Const, Isass, eff., Resp., coughing secondary to reflux, had similar condition prior. However and comparison of End. to old ENG (no new changes compared independent review of images-moderate), prescription management (addition of Regian). Overall moderate.	Patient arrived by ambulance. Coughing, without hemoptysis (respROS), clochest pain (location), stopped on and off (Uming), som (signs). Ext HPI, mos: Resp, ical aand social history. Detailed history.	
Al: Chronic condition with mild progression (coughing secondary to reflux, had similar condition prior-Moderate). review and comparison of exist to old exist (no new changes compared 19-independent review of images-underate), prescription management (addition of Regian). Overall underate.	n Const. Eyes, ent. Resp. CV. skin and neuro. (Detailed).	Resp, const, Gl. Past
	4. Chronic condition with mild progression (coughing secondary to reflux, had similar condition prior. Materate). review and comparison of Exist to old EXIS (no ne 19-independent review of images-underate), prescription management (addition of Regian). Overall underate.	no new changes сотрагек
	Carlifornia Matival Browd	ri fa c agn i

CP (CV) Hx taken from pa AICD to deliver a shock, a b. Comprehensi ve review of rip. Admitted. High Comply riccondary fall (context). In- econdary fall (context). In-	1007/1997 \$188.00 \$165.16 R1.3.2 R1.3.2 B0.5 so \$185 (resp) No CP (CV) HX taken from parametic trip report to the served and fred. Overall low. 10/17/1997 \$186.00 \$65.18 R1.3.2 R0 99283 \$85.18 \$85	\$36.26 \$ Or (CV) Hx taken from paramedic trip report S156.92 S156.92 AICD to deliver a shock, and patient was Comprehensive review of systems. Past mee ip. Admitted. High Complexity S101.93 swith additives) Moderate overall. S208.44		Date Charge Ami	Allowed Reviewers CD CP	CPT CD Rev	Aud CPT	Audited Difference
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\$156.92 AICD to deliver a shock, and patient was D. Comprehensive review of systems. Past me tip. Admitted. High Complexity \$101.93 swith additives) Moderate overall. \$208.44	S156.92 AICD to deliver a shock, and patient wa. Comprehensive review of systems. Past ip. Admitted. High Complexity S101.93 secondary fall (context). Increased back econdary fall (context). Increased back a with additives) Moderate overall. S208.44 e cardiology fellow, Dr. * assumed care	\$156.92 AICD to deliver a shock, and patient was Comprehensive review of systems. Past mer Th. Admitted. High Complexity \$101.93 swith additives} Moderate overall. \$\$208.44\$	trory. EPF hx. Corist, Eyes, Neck. chest, abdomen (deta Persistent voniting (acute uncomplicated * 9 9 2 8 3	ailed) I illness) Treatment-Observed an 3 10/17/1997 \$186.00	. 3 . 2	9	99283	
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S156.92 AICD to deliver a shock, and patient was Comprehensive review of systems. Past mein. Admitted. High Complexity S101.93 swith additives) Moderate overall. S208.44	S156.92 AICD to deliver a shock, and patient was Comprehensive review of systems. Past To. Admitted. High Complexity S101.93 secondary fall (context). Increased back econdary fall (context). Increased back swith additives) Moderate overall. S208.44 cardiology fellow, Dr. * assumed care	\$156.92 AICD to deliver a shock, and patient was D. Comprehensive review of systems. Past mer ip. Admitted. High Complexity \$101.93 secondary fall (Context), Increased back pair s with additives) Moderate overall. \$208.44	staled 99282 period. This is a proble					
52. Sent was ent was 93. 93.	92 193 194 44 4 care	52 16. Past ment was 93 93 44	vorwiting and dizziness since 2300 (signs Constitutional, Eyes. ears, neck. Hungs, in Acute illness with systemic symptoms.(s and duration), No chest pain (be teart, abdomen (detailed exam) vertigo with vomiting), treatment	included IV's with additives C	story. Compazine. O	Verall moderate.	
ent was is. Past mee is. Past mee is. Past mee is. 93	ent wa 15. Past back d care	ent was is. Past mee is. Past mee is. 44	* 92960 ** 92960 ** Service could not be performed Ext		815/.65 K6		C9766	
18. Past 1716 93 back pair	is. Past back d care	ns. Past me 93 back pair	with reviewer. However, this appears to be refred to a sinus rhythm. It is easy to see	e a charging mistake. The dictation is how someone reading the note	n reflects that the cardiologisms not have seen the portion	list came in to n addressing	o reprogram the AICD to deliver a shock, a the AICD.	and patient was
back pair	. 93 . back . 44 d. care	. 93 back pair . 44	dillon, must likely, the leve of service was desired a comprehensive history. Cushing (que.) he to critical nature of case, reminder	denied for the 99285. It should usify, substemal (location), and distributed would be waived.	be considered- aphoresis (signs), did not fer	el his AICD	go off (context), Comprehensive review of	f systems. Past medical
.93 back pair	. 93 back . 44	.93 back pair 44	Acute condition posing threat to life (ventr	men, recurrency cardia, comprehensive tricular tachycardia, rule out MI), I-	studie system caudoogy exiteft saving treatment of bolus's	s of Lidocain	e, Lasix, Nitro-drip. Admitted. High Compl	Hexity
back pain	back 44 d care	back pain	***************************************	02/20/1998 \$323.00	\$101.93 RO R	02	99284	01. 93
S208.44	60 RO 99291 S208.44	99291 O4/23/1998 \$695. 00 \$208. 44 RO RO 99291 \$208. 44	(V+ (Bast t-cell 200 x 3 weeks). ROS: finm titled with 0yeuta (5gm3),EXI HPI, EXI RNC Constitutional, ENT. Neck. Chest. Headt thronic condition with mild progression (c	nunological, neuro, Gl-ext RNS. (IS. past medical (Detailed histor) rt, Abdomen. Extermities, Back. D continued back pain). Treated wi	Chronic(quality) back pain (loca y) Petalled exam Ith IV fluids with additives-der	ation) since 1:	991(duration), secondary fali (context). In zorne. (IV fluids with additives) Moderate	ncreased back pain
and seed out extended as bearings to the 11th conditions follows the **	ent , patient started on h epar in. Looks like cardiology fellow , Dr. * assumed care of 160.93 shoul d De given.					01	99291	44
GAI, PALLEIR SLATTER OII INFAAIR, LOORS LINE CATULOLOGY FOROM, Dr		ent, patient started on hepain. Looks like cardiology fellow, Dr. *	nedic record show patient was in Ed at 13 rould support Dr. * in attendance	3.41, nursing record supports Dr. 1 for at least 39 minufes(exceeding	* prosent, patient st ng 30 minutes).	itarted on he g	yarin. Looks like cardiology fellow, Dr. *	
if cam would not be allowed, the documentation would support 99285 and partial credit of 160.93 should be given.		icam would not be allowed, the documentation would support 99285 and partial credit of 160.93 should be given.	ical cam would not be allowed, the documen	ntation would support 99285 and	d partial credit of 160.93 show	ould be given.		

Audited Difference	3	537.19 \$29.66			\$160.93 \$0.00	08: Complete phe xrays, EKG, discussion with	so. 00 \$101. 93	of the key elements.	so. 00 513. 39			5160.93 50.00	onst, resp, eyes, ent, CV,GI,Gl ion with other physicians Overa	366.85 S0.00), no palpitations (CV) Other ssible neurological changes,
ev Aud CPT		28266	on weight bearing (context). No known altergies per electronic nursing record (part ROS) EPF history.		99285	hx: Patient was on bathroom Scale and passed out (context). fell so hard she dented the door (seventy), having low hack pain (location, signs). Ext hpi. R0S: Complete Past, Social (per nursing record-married,lives with husband). Comprehensive Exam Const, Psych's Neurological, Eyes, ERT, Resp., Cv. Musculoskeleidal Comprehensive exam (ADM: About charge in neurological status (syncopal episode with brief LOC complicated by compression fracture to spine-high), Extensive data: Labs, multiple xrays, EKG, MOM: Aphylicalcalchyth) Treatment: IV. pp meds, and admit. Overall high		Although we agree that presence Is established through the nursing notes, the droumentation is not sufficient to support presence and involvement In the all of the key elements.				99285	ht. on coumadin (modifying factor). at 10;30 (thring), left arm, left leg (location), incoordination (signs), now improving (quality).I Ext hp. Rios: complete: const, resp. eyes. ent, CV,GI,GU, Musculosteletal. Neurologic, Psych, Endocrine, Allergic. Past medical and social (accompanied by spouse). Comprehensive history. Exam. Comprehensive neurological single system exam. MDM: An abrupt change in neurological status (high), treatment with 1V hepaing (drug requiring intensive monitoring-high risk), need for admission-discussion with other physicians Overall high.	99283	Hc Got up because of kep cramps (context), struck forehead on the ground (location), takes ativan (modifying factors). NOS: no foc (neuro), no nausea (GI), no papitations (CV) Other regative (Cn) in the set soch: Thes with husband. Detailed history. Exam Const. Chypeles. PRT. neck, class a abdomen, back, polys, extremibles. Detailed exam MOM. Acute complicated injury (fall with lacoration-neuro checks), treatment; discussion with husband to observe pathnt post discharge frequently for possible neurological changes, instructions to call patient in AM to make sure she was OK neurologically Overall underate.
CPT CD Rev		RI. 3.2	nic nursing r		24	having low h	R13	it to support	R6			RO	ow improving e). Comprel onttoring-high	RO	ng factors) bserve patb
Allowed Reviewers (1)		\$66.85 R1.3.2	known altergies per electro	mnagement) Overall low.	\$160.93 R1.5.4	t (context). fell so hard she dented the door (séverity), at th husband). Comprehensive Resp., Cv. Musculciskeleial Comprehensive examopal episode with brief LOC complicated by compression for and aduit. Overall high.	\$101.93 R13	dhoumentation is not sufficien	\$13.39 R6	ď		\$160.93 RO	ton), incoordination (signs), r ial (accompani ed by spous i (drug requiring intensive m	666.85 R0	cation), takes ativan (modify italied exam iscussion with husband to o all moderate.
Charge Amt	0	\$186.00	g (context). N	چ	6501.60	fell so hard she Comprehensive JSCUKOSKeletal Co with brief LOC α Overall high	5323.90	O notes, the	\$80.60	ot documenta		6501.00	, left leg (local dical and soci in 4V freparing	\$166.69	the ground (lo trow, extremities. De), treatment: d
Date Ch		04/26/1998		xrays Treatment:	04/28/1998	t (context). fell with husband). C Resp, CV. Musc copal episode with S, and admit. Ov.	80	through the nursin	04/30/1998	nof the EKG is r	Ŕ	07/09/1998	timing), left arm. Viergic. Past moe em exam gh), treatment wit	07/09/1998	nck forehead on the band. Detailed his nack, pelvis, cion-neuro checks she was 0K neuro
CPT Cede		99283	ocation), pain(signs)	low), dab review:	99265	cale and passed on record-marred, lives gical, Eyes, ENT, eogical status (syment: IV. po med	99284	nce Is established	93010	hat the inferpretation	scifically documente	99285	actor) at 10;30 (sych, Endocrine, logical single systurological status (hi	99283	amps (context), strain the series with hus cot, chest, abdome ry (fall with lacera AM to make sure
Patient Name		*	Hx: Twisted right foot, ankle (location), pain(signs)	exam rugin 1901 and anko (EFF) MDM: uncomplicated injury (10w), dab review: xrays Treatment: Vicodin	*	hx: Patient was on hathroom scale and passed out (context). fell so hard she Past , Social (per nursing record-marfed/lives with husband). Comprehensive Exam Const, Psych/ Neurological, Eyes, ENT, Resp., CV. Musculoskelelal Co MDM; Abrupl change in neurological status (syncopal episode with brief LOC on their physicians, (high) Treatment: IV. po meds, and admit. Overall high	*	Whough we agree that presen	*	Government auditor states that the inferpretation of the EKG is not documentad	EKG interpretation is not specifically documented.	*	ht: _{on} coumadin (modifying fa Musculoskeletal, Neurologic, P. Exam. Comprehensive neurolc MDM: An abrupt change in neu- high.	*	r. Got up because of leg cri ran droughele). Pert soc ran Const. Pess. Bri. ne DM. Acute complicated in jui structions to call patient in

Audited Difference	666.85 \$0.00	s. Pert past and social. ate Complexity.	\$101.93 \$0.00	ent past history. ith mild progression.	so. 00 \$66.85	rticipated in the	\$160.93 So. 00	Yehensive history. orkup. Hgh 8101.93 (36474)	1/a). GI (N/v), and	- penicillin. Overall		Page 8 of 11
		cc: Feel sick. HPI: rash 4 days (duration), on abdormen and right thigh (location), Itching (signs). Brief HPI, RKS: const (no fever), respiratory, Gl, Psych and allergies. Pert past and social. Exam Constitutional, CV, respiratory, neuro, skin. Detailed. MMM Acute uncomplicated illness (rash, tinea pedis) but combined with abnormal behavior, requiring discussion with other physicians and psych personnel. Moderate Complexity.		Extracting paint (quanty), but knee (tocatori), 4-3 days (duratori), pain increasing (seventy) with waring (context). Extrict (the first context) with the first context of left knee-including musculoskeletal review (tendemess), neurological (without spasm) and vascular flow. 3 systems. Detailed. MM Extensive data forkewed: labs, vascular duplex study, pulse oximetry, EMC plus discussion with primary care physician. Presenting problem is chronic illness with mild progression. (thrombosed vein). Overall moderale.		Reviewer found documentation did not support teaching rules. It is clear from documentation that Dr. * participated in the medical decision making by establishing the final diagnosis of dermatitis. He must also have participated in the examination (cannot diagnose dermatitis without an exam of the skin). The only element not addressed is a paylew of the history.		Hx: feeling weak (signs) for a few days (duration), fait down yester-day (context), unable to walk today (tuning). Ext hpt. ROS: complete. Past, family and social. Comprehensive. Exam Const, eyes. ENT. Resp, cv. GU, Neurological, muculoskeledial. Comprehensive. MMR Advencing renal failure (chronic condition with severe progression-high). Treatment Plan- discussions with other physicians, decision to admit for additional workup. High * 992282 10/26/1998 \$109.00 \$37.19 R2.2.3 R2.2.4 99284	no loc (signs and symptoms(. Ext hpl. ROS: constitional (h/a). GI (RVV), and	Exam: Const, Eyes, Muscufoskeletal, resp, CV, Integumentary, neuro, and psych. (Comprehensive IMM Presenting problem is an acute complicated injury; facial injury, tacial injury with complex laceration. Ruling out neurological involvement. Limitad data-xrays. Prescription meds-penicillin. moderate.		
And CPT	99263	(no fever), respiral ther physicians a	99284	The Finding pain (quanty), but knee (vocabor), 2-3 days (durator), pain increasing (seventy) with wanking (context). Ext FFT, MDS: Respiratory, CV, and . Detailed exam of left knee-including musculoskeletal review (tendemess), neurological (without spasm) and vascular flow. 3 systems. Detailed. MME Extensive data reviewed: labs, vascular duplex study, pulse oximetry. EMS plus discussion with primary care physician. Presenting problem is c (thrombosed vein). Overall moderate.		gnosis of derma istory.	99285	: complete. Past, licians, decision 99284	and symptoms(.	nenf. Limitad d∶		•
PT CD Rev	RO	PI, ROS: const (ussion with oth	R0	axi). Extrinción la amely amel	R13	ng the final dia sylew of the hi	RO	g). Ext hpi. ROS: ith other physi R2. 2. 4	no loc (signs	Aogical Involven		
ewers CD C	. B0	gns). Brief Hi requiring disc	R1. 4. 3	waking (conte	R13	by establishin ressed is a re	R1. 5. 4	lk today (Uming discussions wi R2.2.3	actors),	isive İng out Meuno	·	
GFOUp angle Allowed Reviewers CD CPT CD Rev	\$66.85 F	on), Itching (signal), Inching (signal)	\$101.93 R1.	(severny) wan neurological (n alus discussion	368.85 R	icision making Jement not addi	6160.93	unable to walk hensive. Iment Plan-di S37.19 R	el 3. madin or aspirin (mod	h. (Comprehen kaceration, Ruti		
Community Orgeni Care Medical Group Patient Name CPT Code Date Charge Amt Allowed Rev	5186.00	ght thigh (locatic ned with abnor	\$323.06 \$1	nain increasing w (tendemess), oximetry, EKG ;	\$186.00	the medical de in). The only e	\$501.06	erday (context), seletal. Compre ion- high), Treat \$109.00	it at most supported a level 3. VOUND (locator), not ON counseln or aspiri (modifying factors). Distory.	umo, and psycl with complex		
Ure ivi	07/20/1998	bdomen and riş Detailed. dis) but combin	08/02/1998	ays (durauori), ₁ toskeletal revie ex study, pulse	09/25/1998	hing rules. participated in exam of the sk	10/15/1998	Rait down yesterday (cofgical, muculoskeletal. Cosevere progression- high), 10/26/1998 sine. 00	0AS agreed that this service was undercoded, but felt it at most supported a level 3. Ex. Tripped end fell (context), hit face on Wound (ocation), not On counsoln or aspirit (modifying 6 musculoskelati (neck and pelvis) Pert past. Detailed history.	egumentary, ne ury; facial injury		
rgent Cor	99283	el sick. HPI: rash 4 days (duration), on abdomen s mistory. Constitutional, CV, respiratory. Neuro, skin. Detailed. Acufe uncomplicated illness (rash. Innea pedis) but	99284	The Finding pain (quanty), but knee (weator), 2-3 days. Detailed. Exam. Detailed exam of left knee-including musculos MM. Extensive data forkewed: labs, vascular duplex (thrombosed vein). Overall moderale.	99283	Reviewer found documentation did not support teaching rules. It is clear from documentation that Pr. * participated examination (cannot diagnose dermetrits without an exam of Ni.	99285	days (duration), f yy. Gt, Neurolo; condition with 8	0AS agreed that this service was undercoded, but felt has Tripped end fell (contact) in face on M muscufoskelets (neck and pelvis) Pert past. Detailed	, resp, CV, Ink complicated inj		
V Cr.	6	h 4 days (d respirator illness (66	This rinching pain (quanty), felt kinee (w Detailed. Exam; Detailed exam of left kinee-inc MM Extensive data reviewed; labs, (thrombosed vein), fiverall moderate.	б	Reviewer found documentation did not It is clear from documentation that Dr. examination (cannot disonose dermatiti	ðá	for a few d . Resp, cv ire (chronic o	rvíce was un	culoskeletal		•
RITHURIU Patient Name	*	HPI: rasl tional, CV complicated	*	ain (quanty lexam of e data re ein). Overa	. *	document m document annot diag	*	k (signs) eyes. ENI grenal faik *	et this se end f	Eyes, Mus g problem	Thursday Man 37 2001	i nursaay, may 31, 200

				June					
Patiens Name	CPT Code	Date	Charge Amt	Allowed Reviewers CD CPT.CD Rev	iers CD Ct	T CD Rev	Aud CPT	Audited	ed Difference
*	99284	10/29/1998	\$323.00	\$101.93 R0	RO	0	99284	\$101.93	.93 \$0.00
hx: left arm and pain in neck (location), times 2 days(duration), numbness (signs), increase pain with neck movement (context). Ext hpi. Not past, social. Detailed hx.	k (location), times (2 days(duration)	, numbness (sign	1s), increase pain	with neck m	iovement (a	ontext). Ext hoi.		
Exam: Const, Eyes, ENT, N MDM: Acute cervical strain v moderate	Veck, CVS, Chest, with radiculopathy	Abdomen, Extre (acute illness w	mities, Neuro. De Ith systemic invol	stailed exam-6 syr Ivement). Data rev	stems. riewed: xray	s, díscussio	Exam: Const. Eyes, ENT, Neck, CVS, Chest, Abdomen, Extremities, Neuro. Detailed exam-6 systems. MDM: Acute cervical strain with radiculopathy (acute illness with systemic involvement). Data reviewed: xrays, discussion with other physician, Dr moderate	*	Treatment: Naprosyn Overall
*	99284	11/12/1998	\$323.00	\$101.93 R1.4.3	4.3 R0	v 0	99284	\$101.93	93 \$0.00
Hr: pt eating dinner, went to bathroom (context), feeling Improved while lyir Respiratory, CV, const. Gt. Extende ROS. Pertinent past Detailed History. Exam: Const. Eyes, ENT, Heart, Lungs. Abdomen, Extremities, Neuro (det MOM. Abrupt change in neurological status-near syncopal episode (high), if ambulance, (moderate) Overall moderate	o bathroom (contex Extended ROS. Pe leart, Lungs, Abdoo Irological status-ne rall moderate	t), feeling Improvartinent past Dets men, Extremities ar syncopal epis	red while lying do alled History. I, Neuro (detailed ode (high), limite	own (modifying fac)) id data: labs, ekg i	dor), nearly: (low), IV fluit	fainted twice ds referral to	Hx: pt eating dinner, went to bathroom (context), feeling improved while lying down (modifying factor), nearly fainted twice over last year (timing), feeling dizzy (signs). Ext hpl. ROS: Respiratory, CV, const. Gt. Extended ROS: Pertirent past Detailed History. Mean: Const. Eyes, ENT, Heart, Lungs, Abdomen, Extremities, Neuro (detailed) MDM: Abrupt Change in neurological status-near syncopal episode (high), limited data: labs. ekg (low), IV fluids referral to family physician for re-evaluation, arrived by ambulance. (moderate) Overrall moderate	eeling dizzy (signs). Ext l valuation, arrived by	hpi. ROS:
*	99284	11/14/1998	\$323.00	\$101.93 R1.4.2	4.2 R0		99284	\$101.93	93 \$0.00
ought in by paramedic o relief (modifying fact : Const, Neck, heart, it Acute chest pain (hig	cs, severe chest pa tor). Ext HPI. ROS ungs, abdomen, an th aculty presenting	in (qı ality, locati i: no : ɔb (resp), ı nd extremities (α g problem, posee	ion), radiating do no history of MI (omprehensive sir s threat to life), m	wn left arm and le cardiovascular). P ngle system cardic uttiole data: labs.	ft shoulder, 'ast medical wascular ex eko, way, D	while walkin history and am).	Hx. brought in by paramedics, severe chest pain (q. 3lity, location), radiating down left arm and left shoulder, while walking (context), for about one hour (duration), was given ASA in field with no relief (modifying factor). Ext.HPI. ROS: no. 10 (resp), no history of MI (cardiovascular), Pasts medical history and social. Detailed history, and externatives (comprehensive single system cardiovascular exam). MDM: Acute chest pain (high aculty presenting problem, poses threat to life), multiple data; bits, and vice chest pain (high aculty presenting problem, poses threat to life), multiple data; bits, and vice chest pain (high aculty presenting problem, poses threat to life), multiple data; bits, and vice chest pain (high aculty problem, poses threat to life), multiple data; bits, and vice chest pain (high aculty problem, poses threat to life), multiple data; bits, and vice chest pain (high aculty problem, poses threat to life), multiple data; bits, and vice chest pain (high aculty problem, poses threat to life), multiple data; bits, and vice chest pain (high aculty problem, poses threat to life), multiple data; bits and vice chest pain (high aculty problem, poses threat to life), multiple data; bits and vice chest pain (high aculty problem, poses threat to life), multiple data; bits and vice chest pain (high aculty problem, poses threat to life).	hour (duration), was giv	en ASA in fiel
*	99285	11/18/1998	\$501.00	\$160.93 R0			99285	\$160.93	93 \$0.00
bx: chest pain (location), associated with SOB (signs), pain resolved in ambulance (timing), sharp pain in left shoulder (quality) (Ext Hpi) ROS: Complete, Past, Family and social. Comprehensive history. Exam: Const. eyes, ENT, Resp, Cardiovascular, musculoskelatal, stdn, GU, and neurological. (Comprehensive multi system exam) MDM: presenting problem- unstable angina (high risk-poses threat to life), multiple data: labs, chest xray, EKG (moderate). Treatment or physician, decision to admit. (overall high complexity)	sociated with SOB y and social. Compless, Cardiovascula unstable angina (high coveral) high comp	(signs), pain res xehensive histor rr, muscułoskelei gh risk-poses thy	olved in ambular y tal, skin, GU, and eat to life), multij	ice (timing), sharp i neurological. (C ole data: labs, che	pain in left omprehensi st vray, EK(shoulder (qu ve multi sysi 3 (moderate	bx: chest pain (location), associated with SOB (signs), pain resolved in ambulance (timing), sharp pain in left shoulder (quality) (Ext Hpt) ROS: Complete, Past, family and social. Comprehensive history, Exam: Const, eyes; ENT, Resp, Cardovascular, musculoskeletal, skin, GU, and neurological. (Comprehensive multi system exam) MDM: presenting problem-unstable anginal fully risk-poses threat to fife), multiple data: labe, chest xray, EKG (moderate). Treatment cardiac monitoring, nitropaste, discussion with private physician, decision to admit. (overall high complexity)	uloring, nitropaste, discu	ssion with priv
*	99283	12/08/1998	\$186.00	\$66.85 R1.3.2		R1.3.2	99282	\$37.19	19 \$29.66
Government downcoded to 99282	99282		•						
Hx: oc: Chilis. Brief HPI: Cramps (signs). Pert ROS: Exam: Constitutional: WD BB, Psychological : Alert. MDM: Acute uncomplicated illness (URI), no data re	amps (signs). Pert I B, Psychological : illness (URI), no de	ROS: no known : Alert. Respirator sta reviewed, tre	allergies. Pert so y: Lungs clear. C ated with liquids,	no known allergies. Pert social: lives on street. EPF hx. Respiratory: Lungs clear. Cardiovascular: Sinus rhytm viewed, treated with liquids, and discharged. Overall low	t. EPF hx. Nus rhythm., Overall low.	And Abdom	no known allengies. Pert social: lives on street, EPF hx. Respiratory: Lungs clear. Cardiovascular: Sinus rhytm. And Abdomen: neg. Detailed exam. wiewed, treated with liquids, and discharged. Overall low.		
naronay, may 21, 200									
Confidential Medical Record									

* 99282 122541999 \$109.00 S37.19 R12.1 RD 99282 (201541999 \$109.00 S37.19 R12.1 RD 99282 (201541999 \$109.00 S37.19 R12.1 RD 99282 (201541999 S40929) S409291 Same Control (control), being (location), penderated deep (severity), no excessive bleeding (signal). Brief HRT. Extended ROS: Trapling (neuro), weakness (muskulosteides), and recassed earm and inciding histogrametrially bygien (wound), and musculosteides and and inciding histogrametrially bygien (wound). The Rayles of the second problem forces of an admission of the peneroy (fining), card hold wins (context). Nariang history unitary incontinence hitce this morning (duration). Ext HPI. ROS: Const., cardonascollar, spiratory, and (1. Extended Ros). Penerity has collected. **A second (context). Rest. fung. and context). Nariang history unitary incontented an incontented Ross. Penerity has collected. **A second (context). Rest. fung. and context). Nariang history unitary incontext in deep rest. (context). Rest. fung. and context in the peneroy (fining). Card hold files. **A second (context). Rest. fund. and external rest. Penerod files. **A second (context). Rest. fund. and external rest. Deliabed context. Lides, Rest. fund. and external rest. Deliabed rest. Lides, Rest. fund. and external rest. Deliabed rest. (context). Rest. fund. deliance and lands as and lumber strain). Not context, not context in the primary care and ordito, plan to and it (high risk-threat to less of bodd); and context in market (context). Rest. in fight has referent any example to walk (signs), manhaness in right hand transient (quality). Est this Ros: CV. constitutional, ret at miscuted and seed.). And miscuted deliance complexed context in right hand transient (quality). Est this in miscuted and seed.). Rest.	* 99282 12/25/1998 \$109.00 S37.19 R1.2.1 R0 99282 s. cc. index of see 99291. s. cc. index of see 9929	\$37.19 i, weakness(muskuloskeletal), 8102.07 HPI. ROS: Const, cardiovasculis	\$0.00 so.00 \$0.00
No. Condent ors 99291. Her, Shakes, Operated, Jeff ward (location), penetrated deep (severity), no excessive bleeding (signa), Birld IRPT. Extended ROS: Tragling (neuro), weadness (muskulosteleda), Her, while control (confect), leff ward (location), penetrated deep (severity), no excessive bleeding (signa), Birld IRPT. Extended ROS: Tragling (neuro), weadness (muskulosteleda), Her Shakes, control (secondary), and muskulosteledal system (neuron) (secondary). Performed her hand including incl	S coded es 99391. Second condend, left hand (location), penetrated deep (severity), no excessive bleeding (signs). Brief IBT. Extended ROS: Thopling (neuro eggles. Past medical and social to: Overall EPP Ptc. Gain: Expanded problem focused exam or hand including integrunentary system (neumal), and musculostededal system (ROM Intact). EPF exam dical decision making: acute uncomplicated Injury, prescription treatment with Augmentin. Overall tow. ### Second Control of the Control of Second Con	, weakness (muskuloskeletal), 8102.07 HPI. ROS: Const, cardiovasculá	₩
For imply of context), left hand (location), penetrated deep (severity), an excessive bleeding (signs). Brief inp. 1. while cooking (context), left hand (location), penetrated deep (severity), an excessive bleeding (signs). Brief inp. 3. Section 1. Se	Fig. 19 (2001). The control of context, left hand (location), penaltrailed deep (severity), no excessive bleeding (signs). Brief IRP. Extended ROS: Tringling (neuro ergies. Pst. metical and social Thr. Overall IRP Tr. Overall IRP Tr. Spartied problem forcused exem of hand including integunental with many many and musciculskieled system (RMM intact). BPF exam direct decision making: acute uncomplicated injury, prescription prescription prescription prescription prescription prescription prescription prescription prescription and proposed problem forcused exem of 3020/1999 \$323.00 \$102.07 RI.4.3 RO 99294 Shakes, dyouria (signs), and frequency (fining), can't hold via a (context). Nursing history. Uninary incontinence since this morning (duration), Ext incontinence in the context in the conte	, weakness(muskuloskeletal), s 102.07 s 102.07 e 102.07	<u></u>
### Capacided profering recursion of main fricteding hielegumentary system (wound), and muscioloskeledal system (ROM Inlact). BPF exam discussion mixing: acute uncompleted Injury, prescription pealment with Augmentin. Overall tow. ### S102.07 RI. 4.3 RIO 99294 \$1323.00 \$102.07 RI. 4.3 RIO 99294 \$102.07 RI. 4.3 RIO 99293 \$102.07 RI. 4.3 RIO 89293 \$102.07 RI. 4.3 RIO 89293 \$102.07 RI. 4.3 RI. 4.3 RIO 99293 \$102.07 RI. 4.3 RI. 4.3 RIO 89293 \$102.07 RI. 4.3 RI. 4.4	and: Expanded problem features dearn of hand including integumentary system (wound), and musculoskeletal system (ROM intact). Bry and and a sold of the hand including integumentary system (wound), and musculoskeletal system (ROM intact). Bry assert pit on beginning and the band of the system of operation beginned with system of the syst	S 102.07 HPI, ROS: Const, cardiovasculi	<u></u>
** 99244 03220/1999 \$322.00 \$102.07 Rt. 4. 3 Rt. 99294 \$102.07 Rt.	** 99204 03/20/1999 \$323.00 \$102.07 R1.4.3 R0 99294 ** 99204 03/20/1999 \$323.00 \$102.07 R1.4.3 R0 99294 ** spiratory and G1. (Extended R0S). Perthent Past. Detailed history. ** Am Constitutional, Eyes. neck., healt, lungs, abdomen, neuro (debailed). ** Am Constitutional, Eyes. neck., healt, lungs, abdomen, neuro (debailed). ** Acute complexation of modifying factory, no loc (per ROS), back pain (location). Brief HPI and Pert R0S (EPF history). ** Acute complexated driver (modifying factor), no loc (per ROS), back pain (location). Brief HPI and Pert R0S (EPF history). ** Acute complexated driver (modifying factor), no loc (per ROS), back pain (location). Brief HPI and Pert R0S (EPF history). ** Seb. Back and extremit ties. Detailed exam ** Detailed exam ** Besp. Back and extremit ties. Detailed exam ** Besp. Back and extremit ties. Detailed exam ** Besp. Back and extremit ties. Detailed exam ** Seb. Back and extremit ties. Detailed exam ** Besp. Back and extremit ties. Detailed exam ** Seb. Back and extremit ties. Detailed exam ** Besp. Back and extremit ties. Detailed exam ** Besp. Back and back), and Neuro (DTR. motor and sensory OK)(Debailed). ** Besp. Back and back), and Neuro (DTR. motor and sensory OK)(Debailed). ** Besp. Back and back), and Neuro (DTR. motor and sensory OK)(Debailed). ** Besp. Back and ordio, plan to admit (flight hand transient (quality). Ext hpi. ROS) ** Besp. Back and back). ** Besp. Back and back), unable to walk (signs), numbness in right hand transient (quality). Ext hpi. ROS) ** Besp. Back and Back a	\$102.07 HPI, ROS: Const, cardiovasculi	
Stakes, dyeute (signs), and frequency (fining), can't hold wins (context). Nursing history- urinary incontinence since this morning (duration), Ext HPI, ROS; Const, cardiovascula in Constitutional, Eyes, need, heart, lurgs, abdomen, neuro (defailed). Mr. Multiple data: Labs, EKG, discussion entit other physician(10 consult), Treatment ive and prescription and. (overall moderate) **Multiple data: Labs, EKG, discussion entit other physician(10 consult), Treatment ive and prescription and. (overall moderate) **Multiple data: Labs, EKG, discussion entit other physician(10 consult), Treatment ive and prescription and carterial treas. Defailed exam **Multiple up steps (context), restrained driver (modifying factor), no koc (pert ROS), back pain (location), Brief HPI and Pert ROS (EPF history). **Wilking up steps (context), neck with pain (location), No LOC (pert ROS). Past medical: social. EPF hx. **This is an extractive to the complicated nighty moderate), data review xray L'S spine, CT, consult with primary care and ortho, plan to admit (high risk-threat to loss of bodi richon). Diverall moderate. **Secure of the complicated nighty-moderate), data review xray L'S spine, CT, consult with primary care and ortho, plan to admit (high risk-threat to loss of bodi richon), bear of the context o	spiratory and G. (Extended Risk), and frequency (fiming), can't hold wins (context). Nursing history- unhary incontinence since this morning (duration), Ext spiratory and G. (Extended Risk). Perfitted Past. Delaided history. M. Multiple data: Labs, EKG, discussion ewith other physician(ID consult). Treatment five and prescription mid. (overall moderale) ** B9203	4Pl. ROS: Const, cardiovasculi	
** 99203 O4/09/1999 \$188.00 \$66.51 RO RO 99293 see.51 *** *** *** *** *** *** *** *** *** *	** 99203 04/09/1999 \$188.00 \$66.51 RO RO 99293 **MVA(context), restrained driver (modifying factor), no loc (pert ROS), back pain (location). Brief HPI and Pert ROS (EPF history). **M. Acute complicated riyury (MVA wit th dizziness and lumbar strain). Treated with IM toroidal, flexient. (underate). Overall moderate complexity. **B9283 0510111999 \$186.00 \$66.51 R1.3.2 RO 99283 **M. Kracture lumbar spine (context), neck with pain (location). No LOC (pert ROS). Past medical. social. EPF for. **M. Fracture lumbar spine (acute complicated injury- moderate), data review xray L-S spine, CT, consult with primary care and ortho, plan to admit (high richon). Overall moderate. **B9285 05/17/1999 \$501.00 \$ 1 8 0 . 3 2 R 0 RO 89285 **B9286		% 0.0 %
am Corsts, Cr. Resp. Back and extremit ites. Detailed exam Mr. Acute complexity, restrained driver (modifying factor), no loc (pert ROS), back pain (focation), Brief HPI and Pert ROS (EPF history). ** Sec. 1 Ros. Back and extremit ites. Detailed exam Mr. Acute complexated injury (MVA with dizziness and lumbar strain), Treated with IM forodal, flexentl. (underate), Overall underate omplexity. ** 99283	am Corsts, Cr. Resp. Back and extremities. Defailed exam Mr. Acute complicated tripuy (MVA with dizziness and kumbar strain). Treated with IM forodal, flexeril. (underate). Overall underate omplecity. ### Statistics of the complicated ripuy (MVA with dizziness and kumbar strain). Treated with IM forodal, flexeril. (underate). Overall underate omplecity. ### Statistics of the complexity (MVA with dizziness and kumbar strain). The contract of the complexity of the complexity. ### Fracture kumbar spice (acute complicated ripury- moderate), data review xray L.S. spine. CT. consult with primary care and ortho, plan to admit (high cition). Overall moderate. ### Stouder and back), and Neuro (DTR, motor and sensory OK/Qetailed). ### Practure kumbar spice (acute complicated ripury- moderate), data review xray L.S. spine. CT. consult with primary care and ortho, plan to admit (high cition). Overall moderate. ### Stouder and back), and Neuro (DTR, motor and sensory OK/Qetailed). ### Stouder and back), and Neuro (DTR, motor and sensory OK/Qetailed). ### Stouder and back), and Neuro (DTR, motor and sensory OK/Qetailed). ### Stouder and back), and Neuro (DTR, motor and sensory OK/Qetailed). ### Stouder and back), and Neuro (DTR, motor and sensory OK/Qetailed). ### Stouder and back of the complexity of the complexity of the comprehensive remained and dark the complexity. ### Stouder and sensor of the complexity o	ss6.51	
 Willking up steps (Context), neck with pean (Accation), No LOC (pert NOS). Past medical. social EPF hx. Am: Const.eye, neck , MS (Shoulder and back), and Meuro (DTR,motor and sensory OK)(Detailed). MS: Fracture lumbar spine (acuse complicated injury-moderate), data review xray L-S spine, CT, consult with primary care and ortho, plan to admit (high risk-threat to loss of hodi: neckon). Sp285 05/17/1999 \$501.00 S 18 0 . 3 2 R 0 R 0 99285 Sp285 (Gozalon), lasting several minutes (duration), unable to walk (signs), numbness in right hand transient (quality). Ext hpl. ROS: CV. constitutional, respiratory, at mitter and an accial. Overall comprehensive and misconficial, and misconficial comprehensive exam. 	Willking up steps (context), neck with pain (location), No LOC (perf NDS). Past medical. social. EPF bx. am: Cornst.eye, neck , Ms (Shoulder and back), and Neuro (DTR,motor and sensory OK)(Defailed). Mi. Fracture lumbar spine (acuse complicated injury-moderate), data review xray L.S spine, CT, consult with primary care and oritio, plan to admit (high reden). A 99285 05/17/1999 \$501.00 \$ 18 0 . 3 2 R 0 R 0 99285 ** weakness in left leg (location), lasting several minutes (duration), unable to walk (signs), numbness in right hand transient (quality). Ext hpi. ROS: in million overall comprehensive history. ** Resp. CK. Resp. GL. and musculoskaletal. Comprehensive exam	\$60.51	\$0.00
* 99285 \$501.00 \$ 1 8 0 . 3 2 R 0 R0 99285 \$160.32 \$16	* 99285 05/17/1999 \$501.00 \$ 1 8 0 . 3 2 R 0 R 0 99285 : weakness in left leg (location), lasting several minutes (duration), unable to walk (signs), numbness in right hand transient (quality). Ext hpi. ROS: it medical overall comprehensive history. R man decay and social overall comprehensive history. An unschookelelal. Comprehensive exam	risk-threat to Koss of bodi	11y
weakness in left leg (location), lasting several minutes (duration), unable to walk (signs), numbness in right hand transient (quality). Ext hpl. ROS: CV. constitutional, respiratory, her. Comprehensive accial. Overall comprehensive history. The michal and social. Overall comprehensive history. Const. Eves. Eves. Eve. (TV. Reen Gl. neurolocical, and musculoskeletal comprehensive exam	weakness in left leg (location), lasting several minutes (duration), unable to walk (signs), numbness in right hand transient (quality). Exthpi.ROS: tredical and social overall comprehensive history. sur Const. Eves. ENT. CVS. Reso.G. neurological, and musculoskedetal. Comprehensive exam	\$160.32	50.00
MOM: Acuse TIA (high). extensive data: EMC, x78y, carolid duplex, and discussion with other physician (high).	Mr. Acule TIA (high). extensive data: EMC, xray, carolid duplex, and discussion with other physician (high).	CV. constlutional, respiratory,	, and all
	Thursday, May 31, 2001	Pa	Page 10 of 11
	Confidential Method Record		

ays (durat history. nee), GI: ne vomiti	99265	06/17/1999		THOME WENTERES CD OF I CD NEV		Time Ct 1	₹	Audited Difference
ys (durat history. e), GI: nd vomiti			\$501.00	\$160.32 RI.52	RI. 5. 3	99263		86. 51 893. 61
e), GI: d vomiti	Hx. Vomiting x3 days (duration), No diarthea, no	no few (Pert ROS).	allengic to co	xdeine(ext ROS). RN not	es: weak (signs),	few (Pert ROS). allengic to codelne(ext ROS). RN notes: weak (signs), knee surgery (Modifying factor), unable to ambulate (context). Perf	actor), unable to amb	bulata (context). Ped
	FWITJOH DEFEATION HOUSE. EXAM. MS (right knee), GI: heme negative, CO MOM KNee injury and vomiting (complicate injury fitylityle—indersite) Overall moderate	inst: pulse ox and \ -knee injury in pati	/S's. (EPF exalent with prev	m) /ious knee replacement)	, data mulliple:	Front-off Decalled (1807). Exam NG (fight knee), GI: hence negative, Const.pulse ox and VS's. (EPF exam) MDM Knee billying and vormiblicate injury-knee injury in patient with previous knee replacement), data multiple: Comparison EKGs, ab, discussion with Dr. finythee, undersite injury-knee injury in patient with Dr.	ussion with Dr. *	e and orthopedics.
	99284	07/08/1999	\$323.00	\$102.07 R1.4.3	R2. 4. 5	99265	∞	\$106.32 (\$4.25)
OAS agreed to allow if as a 99283 HX:CVA 2 weeks a og (firning), unab hours (duration). ROS: No dreet pa hours (duration). ROS: No dreet pa fixant Const. Next. Candiovascha MDN: Exame Const. Next. Candiovascha MDN: Exdensive data (multiple 1 las., Documented by the attending as n	OAS agreed to allow it as a 99283 H::CVA 2 weeks ago (timing), unable to unitate, chronic indwelling foley(modifying factor), mild shours (duration). ROS:No chest pain (CV), S08 (resp), NW (GI), Fever chills (Const), pain in thours (duration). RoS:Neck. Cardiovascular, Respiratory, GI, GV, Neuro. (Supports comprehensive s MADH. Extensive data (multiple) also. SYASY, ENS). It is fisk presenting problem, partient with UTI Documented by the attending as needing additional work-up. Overall MM is in in compressity.	chronic indwelling (resp.), N/v (GI), Fr. (GI, GU, Neuro. (Hr risk presenting onal work-up. Overs	foley(modifying swer chilis (Cor Supports cor problem-pati	ifactor), mild suprapublinst), pain in backflank nprehensive single spetent with UTI that has complexity.	c distention (qu (GU). Pert pa ciaty GU exam).	OAS agreed to allow it as a 99283 HX:CVA 2 weeks a og (timing), unable to urinate, chronic indwelling foley(modifying factor), mild suprapuble distention (quality, signs/symptoms, and location) no urinary pressure for 6 hours (duration). ROS:No chest pain (CV), son (resp), Nv (GI), Fever chills (Const), pain in back/flank (GU). Pert past and social Detailed history, and the presenting problems are single specially GU exam). MDM: Extensive data (multiple lass, Xays, ERD). Hit risk presenting problems patient with UTI that has altered mental status associated with confusion while being treated in the ED. Documented by the attending additional work-up. Overall MDM is hith complexity.	l location) no urinary ny. sion while being tr	y pressure for 6 eated in the FD.
by attent	ports presence durin, ding. Due to patient!	Jeefmeni, review (of resident's h Latus and confi	ustory, exam and con uston, we believe the his	lainta appropriate itory is comprehe	Attending documentation supports presence during treatment, review of resident's history. evain and confusion, we believe the history is comprehensive under the coding rules for 99265 and that the overall level is a 99266.	and treatment. All dia 8 for 99265 and that	gnostic studies t the overall level
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MEDICARE PART B CARRIER

August 9, 2001

Department of Health & Human Services
Office of Inspector General
Region IX
Off ice of Audit Services
801 I Street, Room 285
Sacramento, CA 95814-2510
Attention: Jerry Hurst

RE: Audit Report on Community Urgent Care Medical Group

CIN: A-09-00-00089

Dear Mr. Hurst:

This letter is in response to the draft audit report issued by your office as a result of a review conducted for services billed from January 1, 1995 through July 31, 1999 by Community Urgent Medical Group.

We have reviewed and concur with the findings made,

If we can be of further assistance, please give me a call at (213) 593-6834 or Maria M. Hernandez, at (213) 593-6836.

Sincerely,

Carlos **Kivera**, Manager Medical Review Department

Program Integrity



National Heritage Insurance Company
A HCFA CONTRACTED CARRIER
1160 South Olive, Los Angeles, CA 90016-2211
Mailing Address: P. 0. Box 54905, Los Angeles, CA 90054-0905